Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7:30 December 2011 William Sprague Barnard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Symphony Manor Care Baltimore City 8. Date of Birth (Month, Day, Year Social Security Number If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 152-24-0403 Director 1 XM 2 □ F 86 May 20, 1925 Illinois a or 28a-f show be notified at 10h County 10d. Inside City Limits 10c. City. Town or Location Director 1 X Yes 2 No MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a o injury or other traumatic event, the Medical Examiner must be Funeral 4301 Roland Ave. 21210 United States be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married 1 X Yes 2 No ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White Specify: 3 Widowed 4 Divorced Completed Year or Dates.1945~46 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 5+ Medical / Healthcare Chemist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or come. 2 Homes Barnard C. Kenneth Sarah Sprague Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elizabeth Gorham Barnard 701 St. George's Rd., Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Uniformed Sers. Univ. 12/30/2011 Bethesda, MD Rappe and Address of Facility Cremation Services 23a. Part 1. Erker the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Ave., Silver Spring, MD Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Debility years disease or condition Medical resulting in death) Due to (or as a cons- uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner the burial-transit Cause (Disease or injury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregna Ectopic pregnancy in the past 12 months? Month Year Dav Pregnant at time of death the Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by dementin PNUMONIG Fronto remoral 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted Living Hospital Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Director: After 5 Pending work 1 Natural 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical

within 24 hours a 2071

Registrar

State

29a. Certifier (Check

and title of certifier

3 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UHAMES

NI

MM 6701

32. Registrar's Signaty

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 57 PM Physician/ torrax Rampe Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner timore . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number If Under 24 Hrs **Funeral** 86 Months Min Month Day Year 216-96-8775 Philippines 1925 Director 1 🗆 M 2 💢 F 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland at Director items 23a or 28a-f s her must be notified 1 Yes 2 No MD Harford Havre De Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21078 United States 701 Ruddy Ct. filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Examiner Black, White, etc 0 þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Filipino "natural" Completed 3 X Widowed 4 ☐ Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (124 or 5+) the Health Care Book Keeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ Lucio Damasco Felisa Valleio Page 1 and 2 should be traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tractone. Amalia Claudio /Daughter 572 A. Mariano Marcos St. San Juan City, PH 1500 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan 02 cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2012 permit. 22. Na Orematicon family Funeral Alternatives Signature of Funeral Service MO1585 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Myccondia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

9 Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No jo Month Day Pregnant at time of death 5 Other (specify) ped 1 been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 completely filled in by the funeral director, page 2 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗸 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 V Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 3 L ure and title o 29d. Date signed (Month, Day, Year) 29b. Signat 29c. License number MD

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Koneman, MD

Tatthew

31. Date filed (Month, Day, ) JAN 0 3 20

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 42003 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Cer	tificate of	Death	TG TVTOTTG	R	eg. No.	
Physici Pedical Exami		Decedent's Name (First, Middle, La  The second of the	,					2. Date of Dea Month December		3. Time of Death 1143 hrs
)	IIICI	Thomas Byrne  4a. Facility Name (if not institution, gi			4	b. City, Town,	or Location of Dea		r 26, 2011 4c. County of Death	
,		1273 Pekin Court	Pasadena					Anne Arundel		
Funeral Director		5. Social Security Number 6. S			ast birthday)	If Under 1 Ye Months Da		Irs. 8. Date of Bir	th(MM/DD/YYYY) 9. Bird Foreig	
Director		590-84-3070 1XM 2 F 22 Yrs. 05/16/1989						untry) FL		
any		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Location	on				10d. Inside City Limits
faryland 28a-f show	'n	MD Anne A	runde1	Pas	sadena					1 Yes 2 No
Maryla 28a-f d at o	Director	10e. Street and Number	<u> </u>			10f. Zip Code		1	0g. Citizen of What Cour	ntry?
th the Maryland 23a or 28a-f she notified at once		1407 Tar Point					122		United Sta	
ath wi	ner	11. Marital Status  1 X Never Married 2 Marrie	12. Was Decedent   Armed Forces?				lispanic Origin? ( an, Mexican, Pue	Specify Yes or No to Rican, etc.)	- 14. Race - Ameri White, etc.	can Indian, Black,
iffer de	y Fu	3 Widowed 4 Divorce	d If Yes, Give Year	X No	1 🗆	Yes 2 v N	o specify:		Specify: Wh:	ite
nours a	ed by	15. Decedent's Education (Specify of					ation (Give kind o		16b. Kind of Business/l	ndustry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28a-f sh injury or other traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) 12	College (1-4 or 5	+)		•	e. DO NOT use i	eliled)	Caldana	<b>.</b>
215-0036 be filed within 7 ttal Hygiene. rked other than	Com	17. Father's Name (First, Middle, Las	1)		FILI	lwork	18.Mother's Nar	me (First, Middle, N	Cabine Maiden Surname)	Lry
ID 21215-00; should be filed with and Mental Hygiene. 7 is marked other that	Be	Thomas William	Byrne, II	I			Hyun	S. Kim		
D 21 should and Me	ို	19a. Informant's Name/Relationship (	** '						nber, City or Town, State	
e, MD 2 1 and 2 shou Health and Initem 27 is no r traumatie		Ms. Hyun S. Kim / 20a Method of Disposition	Mother	20b. P	8353 J		Hole Ro	ad Mil.  Date	lersville, 1	
nore		1 Burial 2 X Cremation 3		"I	rematory or other			/21/2011	G1 D	MD
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injary or other traum		4 Donation 5 Other Specification 21. Signature of Euneral Service Lice	No. of Section 1	[Atl	lantic (	me and Addre	4 - 10		Glen Burnio	
E E E E		us (.C	7-/.	M011		vices E	A; 1 2nd	Ave SW:	Glen Burni	
Physician \/Medical		23a. Part I. Enter the disease, or comfailure. List only one cause on e	plications that caused t ach line. <b>Cardio</b>	he death. mega]	Do not enter the ly with	bivent	g, such as cardiac ricular	or respiratory arre dilatati	est, shock, or heart . <b>On</b>	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse			e use				Death
		Sequentially list conditions. b								
	Examiner	if any leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):							
d sit	хап	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
xecuted n and 1 - transit		Q.								
o o o o o o o o o o o o o o o o o o o						23d, Date of delivery	-			
x 687 h certifica ending pl		23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Feta	Il death 3	Ectopic preg	nancy		ay Year
Box 687  death certific  the attending property of for use as the	Physician	1 Yes 2 No 9 Unknow	Pregnant at t  Unknown	ime of dea	oth	er (Specify)				
P.O. B as that the de gned by the		Part II. Other significant conditions	contributing to death	but not re	sulting in the un	derlying cause	given in Part I.	23e. Did to	bacco use contribute to	he cause of death?
S, P.C.	bd by	Narcotics (Metha	done and 0	хусос	done) and	d Alpra	zolam us	e 1 Yes	2 No 3 Prob	ably 4 🗹 Unknown
ords aw requias been 2 should	Completed				_			24a, Was a autop	sy prior to o	opsy findings available ompletion of cause of
tal Rec	S							perfor 1 ✓ Yes		s 2 No
ital ician: s certif rector,	B	25. Was case referred to medical examiner?	Hospital:		FDIO 1 - 1 - 1		of Death (Chec			
of Vital Records, of Physician: The law requirements this certificate has been sineral director, page 2 should the	2	1 Yes 2 No 27. Manner of Death	28a. Date of Injur (Month, Day,Ye		ER/Outpatient 28b. Time of Inj		Other Nurs		Residence 6  Other	Scene
ion tendin tor: A	Certification:	1 Natural 5 Pending 2 Accident Investigat		ar)		1	Yes 2 No			
Division tal or Attendi 13 after death. 14 Director: //	tifica	3 Suicide 6 Could not	be 28e. Place of Inju	ıry - At hor	me, farm, street	, factory, office	building, etc.	28f. Location (S or Town, St	Street and Number or Ru	al Route Number, City
Div ospital or hours afte aneral Div y filled in		4 Homicide determine	(openiy)							
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only	r:On the basis of exam						e(s) and manner as state and place, and due to the	
To with	Ř	29b. Signature and title of certifier	and manner stated.				se number		29d. Date signed (Mon	
		Whell 2				0.0	.M.E.	9	December 27, 20	11
1		30. Name and address of person who				01	D-W	4D 04000		
	ata		nt Medical Exam				, Baltimore, N	1D 21223	<del></del>	
Regist	rar	31. Date filed (Month, Day, Year) JAN U 3 2012	Coneur	B. 1	park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 42004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Weldon Miller Clinton, Sr. Dec. 31 1:10 P. M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll 1706 Kempfield Drive Hampstead Social Security Number 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** April 21,1939 Hours Maryland 215-36-8027 Director 72 1 🔀 M 2 🗆 F Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits 10c. City, Town or Location must be notified at Director Carroll Westminster Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a United States 21157 86 Winchester Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1959 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Examiner Black, White, etc. ō þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify. 1961 White "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Carpet/flooring Construction Worker 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o Naomi Miller ဂ Department of Health and Ment. Important: If item 27 is marked any injury or other Clinton be John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 131 South Clear Ridge Road New Windsor, MD 21776 Weldon Clinton, Jr. - Son altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State cemetery, crematory or other place)
Bethany Cemetery Jan. 4, 2012 New Windsor, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat e f Funeral Service Licensee 22. Name and Address of Facility Funeral Home & Crematory, PA liberty Road Winfield, MD 217 Burrier-Queen Fart 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death etastape Ph. sician/ 04 e or condition Medical resulting in death) **Examiner** Sequentially list conditions, the pure list of the cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine burial-transit Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the at id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? this certificate 1 Yes 2 No 9 Hospital or Attending Physician; 24 hours after death. Funeral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1704 Remtield Dr Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hampstead, nD 1 ☐ Yes 2 ☐ No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) selo 52035 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 295 Wertminster Mo 2115+

Registrar

State

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Maryland 7 1992 time of drawing and Mental Hygiene 20 | | ITEM# 2 per PHYS, 6924, 21/2012, WS Reg. No. 42005 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3130 December Physician/ 2011 11:45 p<sup>M</sup> Sallv Coulter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Fairhaven Svkesville 5. Social Security Numbe 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 M 2 TXF Days Hours OCT 30. T916 Pennsylvania 185-07-6604 95 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director 1 Yes 2 x No Maryland Carroll Sykesville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 7200 Third Avenue 21784 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Buyer Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John A. McGeehan Sarah Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette Jeffrey/niece 2110 Edmondson Avenue Catonsville, MD 21228 20b. Place of Disposition (Name of Valley of the Sun Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 1/6/2012 Chandler, Arizona 22. Name and Address of Facility Haight Funeral Home & Chapel, P.A P.O. Box 195 Sykesville, MD 21784 21, Signeture of Funeral Service Licensee (410 - 795 - 1400)23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. dementia Onset and Death Immediate Cause (Final end Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed page 2 should peen 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? has 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4\* Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes မှ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check eqtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 150 brace 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ana I. Sarante 1645 Liberty Rd. suite 204 Eldersburg, Md 31. Date filed (Month, Day, Year) .\_\_\_ State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 11:32a <sub>M</sub> 2. Date of Death Physician/ December 2011 ANDREA SHARLE CREWS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3713 Walters Lane PG District Heights Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2XXF Days Hours 01/12/6/14/957 54 Director 579-74-0930 lashington. DC Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD District Heights 1X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 3713 Walters Lane 20747 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Armed Forces þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: 3 - Widowed 4 - Divorced If Yes, Give Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Executive Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Furman Harris, Sr. Ruth Ella Paige 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20001Jeffrey Crews (Husband) 66 New York Avenue, N.W. #103; Washington, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 MBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 12/31/2011 Suitland, Maryland Signature f Funeral Service Lid 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, MD 20748 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or lyone cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition nous Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) bunial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, cate has been sig ; page 2 should b 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 X No 2 🗷 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\overline{\mathbf{x}}$  Residence 6  $\square$  Other (Specify) ٥ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending death. ie Hospital or Attendii 24 hours after death. ie Funeral Director: A 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tipe of certifie 29d. Date signed (Month, Day, Year) 2500 2-28-11 30. Name and address of person pleted cause of death (Item 23a) (Type, Print) Largo, md

DHMH 17 Rev 7/2009

State

Registrar

JAN U 3 2012

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month robect Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Rosedale Baltimore Franklin Social Security Number If Under 1 Year If Under 24 Hrs. Min. Age (In yrs. last birthday 8. Date of Birth **Funeral** Davs Hours (Month, Day, Year) Director 1**X**M 2 □ F 7 5 show 10a. State 10b. County with the Maryland 10c. City, Town or Location notified at Director 28a-f = SS e> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ems 23a or r must be r Funeral 33 USA items 2 Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status 12. Armed Forces? Black, White, etc. Clark, Robert ō þ 1 Never Married 2 Married Examir Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates "natural", Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important; If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Pharmac 19 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date VWK Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 ☐ Other (Specify) 21. Signatur Pin al Service Licer 22. Name Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest. or heart failure. List only one cause on each line Immediate Cause (Final Physician. a listerios clerotic disease or condition lar Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a nonsequence of, If any, leading to immediate cause. Enter Underlying Exami Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury eral Director. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 24a. Was an autopsy performed? Yes 2 No 24 hours after death, Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at iniury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 🗌 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Medical within 24 hor To the Fune completely fi (Check only one)

Approximate Interval Between Onset and Death 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 12/19/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RODEST filed (Month, Day, Year, ranklin Drive 32. Registrar's ignatur JAN 0 3 2012 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Birthplace (State or Foreign Country)

White

10d. Inside City Limits

Yes 2 No

24 PM

DHMH 17 Rev 06-2011

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42008 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Eleonora Caputi 8:454 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 8809 Church Field Lane 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 89 024-30-3128 Director 1 🗆 M 2 ី F Nov. 4, 1922 Italy Usual Residence of Decede 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 X No Prince George's Laurel MD o 10e, Street and Numbe 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? USA 8809 Church Field Lane 20708 within 72 hours after death Was Deceud.
Armed Forces?
Ves 2 X No 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, an "natural", or iter Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed Specify: White 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within thygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Quality Inspector and Mental Hygie is marked other event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Federico Grossi Rosina D'Andrea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8809 Church Field Lane, Laurel, MD 20708 Rosetta Maria Agres / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Ivy Hill Cemetery 12/28/2011 Laurel, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01581 313 Talbott Ave, Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consiquence of Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Inneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \(\sum \) Nursing Home 5 \(\overline{A}\) Residence 6 \(\sum \) Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ms Ray apartne M.D 00057465

Registrar

DHMH 17 Rev 06-2011

State

nv

2835 Smith AV

32. Registrar's Signature

5 203

Baltimore MD Z1209.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. s. Rajapakse M.D.

31. Date filed (Month, Day, Year,

JAN 0 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 42009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 4:30A 2. Date of Death Physician/ DECEMBER30,2011 Joseph Czajkowski, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE SAINT JOSEPH MEDICAL CENTER TOWSON 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Jan 13, 1924 216-16-6233 Maryland **Director** 1 X M 2 🗆 F 87 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director iral", or items 23a or 28a-f s Examiner must be notified MD Baltimore Timonium 1 🗌 Yes 2 🗶 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12240 Roundwood Road 21093 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 nan "natural", o If Yes, Give 142-145 Year or Dates. 1 Yes 2X No Specify. Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene. 27 is marked other than "r traumatic event, the Med life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Commercial Artist WBAL-Television Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Czajkowski Sarafina Kaminski Joseph other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other transcence. Joseph H. Czajkowski, Jr.-son 3 Sherborne Ct., Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Parkwood Cemetery 01/03/12 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. William G. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate DAYSnd Death Immediate Cause (Final ASPIRATION PNEUMONIA Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** DAYS ORAL PHARYNGEAL DYSPHAGIA Sequentially list conditions Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires SEVERE CARDIOMYOPATHY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed neec DEBILITY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed? Yes 2 N certificate 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After 1 X Natural 5 Pending 2 Accident death. 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1-X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Manth, Day, Year) D61731

41

DHMH 17 Rev 06-2011

Registrar

7601 OSLER DRIVE TOWSON, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

REGINA GAN-CARDEN, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 30, 2011 Year Dong Hwa 5:23 A. Chong Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Baltimore Towson 5. Social Security Numbe 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign
Country) **Funeral** Hours 215-31-6589 1X M 2 □ F **Director** S. Korea 65 July 10, 1946 Yrs Usual Residence of Deced 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at **Funeral Director** Maryland Baltimore 1 ☐ Yes 2 🎇 No Nottingham 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? items 23a 8375 Tapu Court 21236 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. med Forces?

Yes 2 X No Black, White, etc. ö Completed by 1 Never Married 2 XMarried If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify. "natural", Specify. Korean 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Self-Employed Grocery Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic onee. Nak Young Chong Park Kuv Duk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8375 Tapu Court Nottingham, Maryland 21236 Hae Chong / wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Hillton Service Corp. 1/2/2012 Towson, Maryland 21. Signature of Tuner Sep 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 a 23a. Part 1. Enter the disease, or com-shock, or heart failure. List only works that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ COM Cell gas NLIC months disease or condition Medical resulting in death) Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 D Other (Specify) Waspie 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar

Medical

27. Manner of Death

1 Matural

2 Accident
3 Suicide
4 Homicide

29a. Certifier

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

5 Pending

Investigation Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHAPLES MD

DHMH 17 Rev 06-2011

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N.

28c. Injury at

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Chrone ST TOWSON

work

1 Tyes

The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 🗌 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Decrimber

21201

29d. Date signed (Month, Day, Year)

30

Loil

28a. Date of injury (Month, Day, Year)

6701

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month DECEMBER 19 2011 Physician/ 11:20 M Hazel Elizabeth Dorsey Medical 3 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Good Samaritan Hospital Baltimore 08 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Hours 1 □ M 2 🗗 F Director 216-34-4192 Nov. 28, 1935 Maryland 76 Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 □ No notified N/A Baltimore Mary.land 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a (1) 21218 USA 1419 Kingsway Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, injury or other traumatic event, the Medical Examiner Armed Forces? Black, White, etc. ō Completed by 1 Never Married 2 Married Specify Black altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates "natural", 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working ifiled within 72 tal Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) CNA Nursing Home Be JORSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Dorothy Jordan permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. Eli Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxanne Hayes/Daughter 1919 E. Belvedere Avenue Baltimore, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gardens Timonium, MD 22. Name and Address of Facility Chalman-Harris Funeral Home 21. Signature of Funeral Service Licensee 4210 Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ BRADYCARDIA disease or condition Medical resulting in death) Examiner BRAIN EMCEPHALOPATHY ANOXIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner MY PERCAPMIC RESPIRATORY PAILURE ACUTE burial-transit and Due to (or as a consequence of): attending physician Physician/Medical ASTUMATICUS The law requires that the death certificate be STATUS Division of Vital Records, P.O. Box 68760 as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has filled in by the funeral director, page 2 performed' 1 Yes 2 No After this certificate 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 Natural 5 Pending 24 hours after death. Funeral Director: Al 1 🗌 Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5000 DECEMBER 19 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCURAVEN BLVD SARAT BALTIMO 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2 0 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mable Madden Dixon Physician/ Month 12-21-2:00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3222 Dudley Ave. Baltimore N/A Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 214-18-1370 1 🗆 M 2 🔀 F Days Month, Day, Year) 13/1922 Director 89 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits notified MD N/A Baltimore 1 XYes 2 No 10e. Street and Number items 23a or ner must be n ō 10f. Zip Code 10g. Citizen of What Country? Funeral 21213 3222 Dudley Ave. USA permit. Page 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items;
any injury or other traumatic event the Madical 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. چ 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 3rd College (1-4 or 5+) Baltimore City Custodian N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Marish Mable Moore ဂ္ Charles Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Knox - Daughter 3222 Dudley Ave. Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Holy Redeemer Cemt 12/30/201 1 X Burial 2 Cremation 3 Removal from State Baltimore, MD 4 Donation 5 Other (Specify) Signature of Fun and Service Licensee 22. Name and Address of Facility March F/H East 1101 E. mille North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph. sician/ disease or condition resulting in death) Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Live Birth 2 Live Birth 2 Pregnant at time of death Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? Yes 2 M No certificate 4000 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify, 2 X No within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation
6 Could not be Accident Suicide 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

X DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Janp 6701 N. Ch

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

8008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:20 AM M Physician/ Month December 31, Year011 William E. Davenport Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Glen Burnie Health & Rehab Anne Arundel Glen Burnie Social Security Number If Under 1 Year | If Under 24 Hrs. Sex X 1 M 2 F 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 85 02713/1926 Pennsylvania **Director** 197-16-5043 Usual Residence of Decede 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Director notified 1 🗌 Yes 2 🎽 No Maryland Anne Arundel Glen Burnie 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō pe ms 23a Funeral United States 21060 119 Castle Harbour items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14 Race - American Indian Black White etc. or, þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates er than "natural", the Medical Exan 1944 - 1946 Specif White 3 Widowed 4 Divorced Completed Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Drug & Alcohol Therapist event, th Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. မ Unknown Charles Davenport 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ashbrooke Drive West Chester, PA 29380 William C. Davenport Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Jan 03 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) Baltimore, MD 2012 Metro Crematory, Inc. 4 Donation 5 Other (Specify) 21. Signature of Funeral S 22. Name and Address of Facility
Stallings Funeral Home, P.A. 3111 Mountain Road Pasadena Maryland 21122201 se, or complica 23a. Part 1. Enter the disashock, or heart failure that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No for Month Dav Pregnant at time of death been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2. No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autops Yes 2 No 1 Yes 2 No certificate the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: ျ 1 Tes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Septifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the the only one 29b. Signature and 29c. License number

State

address of person who completed cause of death (Item 23a) (Type, Print)

For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 2 Year Margarete M. Dickerson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Anne Arundel Glen Burnie Social Security Number 9. Birthplace (State or Foreign Country) Germany If Under Year If Under 24 Hrs. **Funeral** 8. Date of Birth 1 M 2 XF Yea 1925 June 28 86 Director arat 578-42-4902 28a-f shov 10a. State 10b County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at Director MD Anne Arundel **Odenton** C 10e. Street and Number 10g. Citizen of What Country? ò 10f. Zip Code Funeral 23a 1208 Odenton Road, Apt. 310 21113 USA items 0 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Purchasing Agent Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sae1z1er Friedrich Mathilde 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Dan T. Dickerson, son 8208 Edwin Raynor Blvd. Pasadena, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 12/30/11 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Una. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine that initiated events resulting in death) Last Due to (or as a consequence of) -burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the phy use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months.
1 Yes 2 No for Month 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has birector, page 2 s performed 1 Yes 25. Was case referred to medical examiner? Be funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 100 2 1 Yes 10 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Man of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day Year) ecember 30. Name and address of person who completed cause of death (Item 23a) Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

42014

10d. Inside City Limits

**Belz** 

Inc.

21228

Approximate Interval Between

Onset and Death

Day

2 No

Year

1 ☐ Yes 2**X** No

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

Please Type or Printin Black Indelible diks Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 42015 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert Downs, Jr. December 2011 3:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ma Maison Assisted Living Nottingham Baltimore Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Min 212-22-9244 1 🛂 M 2 🗆 F 84 Director 8/9/1927 MD Usual Residence of Decede 28a-f show 10a. State the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2X No MD BALTIMORE FULLERTON 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö must be r Funeral 4113 PERRY VIEW RD 21236 USA Page 1 and 2 should be filed within 72 hours after death with items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Examiner Black, White, etc. WHITE o, þ 1 Never Married 2 Married TYPES 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural" 3 ★ Widowed 4 □ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 Eternentary/Secondary (0-12) r than the M College (1-4 or 5+) of Health and Mental Hygiene. Item 27 is marked other that other traumatic event, the N SUPERVISOR TELEPHONE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ LILLIAN BOOTH ROBERT DOWNS, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JARRETTSVILLE, MD 21084 CRAIG DOWNS-SON 2310 BIRMINGHAM CT 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ₽ Department of Important: If it any injury or o 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State MORELAND CEMETERY 12/27/11 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME Signature of Funeral Service Licenses 9705 BELAIR RD BALTIMORE, MD 21236 Part 1. Enter the disease shock, or heart failed. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician/ 0 262 prov disease or condition Medical resulting in death) Examiner arcinom Secure tally list for althors if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physiciar Physician/Medical MOK Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 L Fetal dea 3 Ectopic pregnancy5 Other (specify) ģ in the past 12 Month Dav Year should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy page 2 24 hours after death.
Funeral Director; After this certificate 2 No 1 Yes the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Assisted <sub>ify)</sub>Living Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1. Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 28, 29/1 Physician/ Davis William 2359 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 1419121 10 1h Mor Birthplace (State or Foreign Country) If Under If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) **Director** 215-53-6933 1 **X** M 2 □ F 13 Sept 1, 1998 Maryland Usual Residence of Decede items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Baltimore Phoenix 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14025 Phoenix Road 21131 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 X Never Married 2 Married þ 2 **X** No Baltimore, Maryland 21215-0036 1 Yes If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4 or 5+) 07 Ith and Mental Hygien 27 is marked other the traumatic event, the n/a Student Education Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Stephen Davis Healy Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : If item 27 is or other tra John and Mary Davis/Parents 14025 Phoenix Road, Phoenix, Maryland 21131 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or conce. 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify Fairview Cemetery 1/3/12 Phoenix, Maryland 22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Road, Home of Dulaney Valley Inc. Road, Timonium, MD 21093 Clary Part 1. Enter the disease, or compleshock, or hear, failure. List only on hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, n each line. Approximate Interval Between Immediate Cause Final Onset and Death Physician/ REFRACTORY HYPOTENSION Medical resulting in death) Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Unknown signed by the at d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed?

1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital 일 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Tes 2 🗌 No hours after death ineral Director: A Accident Investigation 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 1255000

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEFFEN

KATHERINE

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Decemb 20:15 PM Donnia L. DeLuca 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 2105 Arden Drive Fallston Social Security Number 7. Age (In vrs. last birthday, 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Sept. 1, 1944 Months Davs Hours 216-40-0950 Maryland **Director** 1 M 2 XF 67 Yrs Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Harford MD Fallston 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2105 Arden Drive 21047 USA and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes Give white 'natural", 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) i Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Pub Tavern Manager 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Arthur Boemmell Regina McDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a Michael DeLuca, Sr-spouse 2105 Arden Drive-Fallston, Maryland 21047 injury or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 tX☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cemetery Dec. 30, 2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician Lan disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be as the IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Vear Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director After this certificate I completely filled in by the funeral director, pag 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a, Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 5  $\square$  Pending 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

Gany Apple boun mp 6934 Aviation Blud 21061 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 27 Day Physician/ 2011 Leonard Howard Dilworth 4:35 Ρ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Co. 1019 Shoreland Drive Glen Burnie 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours (Month, Day, Year) Director 216-34-1763 72 02/23/1939 Marvland Usual Residence of Decedent show 10h County 10d. Inside City Limits Oa State 10c. City, Town or Location ŧ the Maryland Director notified 28a-f 1 Yes 2X No MD Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 must be Funeral 23a with 1019 Shoreland Drive U.S.A. 21060 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after death 12. Was Decedent Ever in U.S. 14. Race - American Indian. Was Decedent 2.5. Armed Forces? 1 ☐ Yes 2 XNo Examiner Black, White, etc. 0 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Grocery Store 12 Assistant Manager other traumatic event. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Page 1 and 2 should be Leonard Joseph Dilworth Nina Maude Heath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a: If item 27 i Mrs. Virginia Dilworth / Wife 1019 Shoreland Drive Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 9 Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Glen Haven Mem. Park 01/03/2012 Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation Signature of Funeral Service Services, PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transif Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be P.O. Box 68760 the use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Dav 5 Other (specify) signed by the at d be detached for Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 or Attending Physician: The law requires Division of Vital Records, 2 No 3 Probably 4 Unknown Yes Yes Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? has page 2 death? 2 No after death.

Director: After this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 🗌 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Cescribe how injury occurred 28c. Injury at injury "X Natural 5 Pending work?
1 Yes 2 No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 29b. Signature and title of certifie 29c. License number

DHMH 17 Rev 06-2011

State

Registrar

30. Name and address of person

ed (Month, Day, Year)

JAN 0 3 2012

arko

21061

completed cause of death (Item 23a) (Type, Print)

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42019 1 - State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ ewaele 2321 December 1011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death It More Cit topkin 6. Sex If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Age (In) s. last birthday **Funeral** 147-72-4608 42 Director 1 M 2 XX 6/5/1969 New Jersey show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f MD 1 Yes 2XXNo Anne Arundel Severn 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? must be Funeral 23a with USA 1218 Delmont Road 21144 death y Iral", or item 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2XX Married Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or Yes Yes Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2XXNo Specify Specify. Completed 3 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the 4 Teacher Education traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Greenwald Roy Mark Anne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregg Dewaele / Husband Severn, MD 21144 1218 Delmont Road other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State Department o Important: If any injury or once. P 4 Donation 5 D Other (Society) 1/2/2012 Atlantic Crematory Glen Burnie, MD Signature & Funeral Stavic Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a con a guence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transi cancel Ta Due to (or as a consequence of): anding physician and use as the burial Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No for Day Month Year Pregnant at time of death
Unknown signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? this certificate 1 Yes 2 No 2 No • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tyes 2 🗌 No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wolfe St. Coope MICHOL 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17&18 Per TNF G923 1/12/2012 III State of Maryland? Department of Health and Mental Hygiene For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 23 Physician/ 442 DM Lorette Davis Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner 4c. County of Death SEHERGI Ci N/AHMUYE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 □**攵** Min. 220-64-0542 1073771956 Maryland 55 Yrs Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County ortant. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medic 4 Ex miner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director N/A 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2003 Sinclair Lane 21213 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Be Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 **X**No 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) John Hopkins College (1-4 or 5+) years Elementary/Seconday (0-12) Phlebotomy Wyman Park Maryland 18. Doilectes (No VadleStaden urname) William Leroy Jenkins ဂ္ Dolores Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley Davis(husband) 6638 RidgeborneDr., Baltimore, MD 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important; If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) on-site Crematory 12 29 1( Baltimore, MD 21. Signature of Funeral Service Licensee ታሪሄቄዎሽ<sup>ለ</sup>ቸ®፣∘ቹቸውwn Jr. Funeral Home PA an y Dane Fulton Ave., MD 21217 2140 N. Baltimore, 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a co Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month Year Day Pregnant at time of death 1 Yes 2 T 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? After this certificate ☐ Yes 2 No 1 ☐ Yes 2 🔀 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: 잍 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending iniury work?
1 Yes 2 No Accident Investigation Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) TMM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINCEN SAMIR TAN Year) Registrar's Signat State Registrar

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attriew James		r State of Maryland / Departme 1-For State Amend I tems 28a-f per mergy Certifica	nt of Fleatin and wiental rivgi te of Death	Reg. No. 2011 4202				
Physicia	an/	Decedent's Name (First, Middle,Last)	2. [	Date of Death 3. Time of Death				
odical Exami ا	ner	Matthew James Darr  4a. Facility Name (if not institution, give street and number)	4b, City, Town, or Location of Death	Month Day Year 1201 hrs December 30, 2011 1201 hrs				
		4 Waterway Court #1B	Towson	Baltimore County				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	" I TO I TO I TO I	Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign				
Director		218-72-2289 <sub>1</sub> <sub>M 2</sub> 53	Yrs. Months Days Hours Min.	11/17/1958 Country) Maryland				
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	r Location	10d. Inside City Limits				
<b>*</b>	5	MD Baltimore Tow	son	1 Yes 2 X No				
Maryl: r 28a-f	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?				
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once		4 Waterway Court #1B  11. Marital Status   12. Was Decedent Ever in U.S.	21286  13. Was Decedent of Hispanic Origin? ( Specif	V Yes or No- 14. Race - American Indian, Black,				
leath w	Funeral	1 Never Married 2 Married Armed Forces?  1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto Rica					
after c	P, F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:	Specify: White				
hours "natur			ecedent's Usual Occupation (Give kind of work uring most of working life. DO NOT use retired)					
5-0036 led within 72 Hygiene. other than '	Completed		aster Plumber	Aquarium				
iled w Hygie d other		17. Father's Name (First, Middle, Last)	5.791	st, Middle, Maiden Surname)				
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	To Be	Jack E. Darr  19a. Informant's Name/Relationship (Type, Print)  19b.	Mailing Address (Street and Number or Rura	Wurdack Il Route Number, City or Town, State, Zip Code)				
MD 12 show the and 27 is umatic			354 Hallmark Rd., Cla					
imore, WE Pages 1 and 2 si nent of Health ar ant: If item 27			y or other place)	ate 20c. Location - City or Town, State				
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specify:		/2012 Towson, MD				
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		21. Signature of Funeral Service Licensee William G. Dau	22. Name and Address of Facility Ruck 1050 York Rd., Tow	Towson Funeral Home, Inc.				
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	enter the mode of dying, such as cardiac or res	spiratory arrest, shock, or heart Approximate Interval				
Medical Examiner		Immediate Cause (Final disease a. Narcotic Intoxication						
		b						
	ne	Sequentially list conditions,  If any, leading to immediate  Due to (or as a consequence of):  cause, Enter Underlying Cause						
1/2 =	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
an and al - trans	CalE	d.  X UNPENDED AMENDED 23a, 27, 28a	f,per me,g924 2-3-12	Cm Cm				
		IF FEMALE: 23a. If yes, outcome of pregnancy	7 per me, g924, 02/09/2	012dhb 23d. Date of delivery				
687 certifica ding pl	ian/	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregnancy	1.00				
Box 6 death cer he attendii d for use a	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)					
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ls, P.C quires that en signed uld be deta		-		1 Yes 2 No 3 Probably 4 Unknown  24a, Was an 24b, Were autopsy findings available				
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Vita hysicia this cer	To Be	1 V 165 2 140	- 0"	ome 5 Residence 6 🗹 Other Scene				
n of ding Pl	ä	1 X Natural 5 (Month, Day, Year)	1 Van 2 3	d. Describe how injury occurred				
ision Attencer ar death rector: by the	icati	2 Accident Investigation 28e. Place of Injury - At home, fan	1:45 am	28f. Location (Street and Number or Rural Route Number, City				
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or income.	n occurred at the time, date and place, and due	e to the cause(s) and manner as stated.				
To th withi To th	Medical	and manner stated.  29b. Signature and fifte of certifier	29c. License number	29d. Date signed (Month, Day, Year)				
		(Istalace of A)	O.C.M.E.	December 31, 2011				
d l	1	30. Name and address of person who completed cause of death (Item 23a)						
<b>W</b>	3 //	Laron Locke MD. Assistant Medical Examiner 900 V		21223				
Si Regis	tate		1					

11-09625 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Gloria Etheridge State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day December 23, 2011 Medical Examiner Etheriag 0134 hrs oria 4a. Facility Name (if not institution, give street and riumber) 4b. City. Town, or Location of Death 4c. County of Death Union Memorial Hospital **Baltimore** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In vrs. last birthday) Foreign 219-42-9907 Director Hours Country) Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10f Zip Code 10g, Citizen of What Country? 21218 Guiltord Ave USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Yes Specify: Black 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 No specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21/2 Baltimore 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) USCar Bullock ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Guilford Are 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 1 Burial 2 Cremation 3 Removal from State 30/2011 Kanda Donation 5 Other Specify Signature of Funeral Service Licenses 22. Name and Address of Facility Harch F/H -East Baltimore 21202 23a. Parl I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onsat and Medical Death a. Metastatic lung carcinoma Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit ian/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day Fetal death Month Year past 12 months? Physici Pregnant at time of death Other (Specify) Yes 2 No 9 ✔ Unknown 9 Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 Yes 2 No 25. Was case referred to medical the funeral director, 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural Pending 1 Yes 2 No To the Funeral Director: Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DHMH 17 Rev 1/2001 OCMF 2006

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

December 24, 2011

Lawrence Edwards
11-09472 Please Type or Print

1-09472 nk Unk		Please Type or Print in Black Indelible State of Maryland / Department				1	1 1 202
		1- For State Registrar  1. Decedent's Name (First, Middle,Last)		ia ivientai i i	F	201 Reg. No.	
Physicia Ledical Exami		Lawrence Edwards				Day Year Pr 16, 2011	3. Time of Death 2145 hrs
)		4a. Facility Name (if not institution, give street and number) Sinai Hospital	4b. City, Town, o Baltimore	or Location of Deat	1	4c. County of Death	1
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Da		_		thplace (State or in MD untry)
		Usual Residence of Decedent	Yrs.		May 9	, 1988 co	
nd ibow any ce.	-	10a. State 10b. County 10c. City, Town or Loc Maryland N/A Baltimore					10d. Inside City Limits
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinet must be notified at once.	Director	10e. Street and Number 3600 Clifton Avenue	10f. Zip Code 21216			10g. Citizen of What Cou USA	ntry?
ath with t tems 23s	Funeral		Was Decedent of H If Yes, specify Cuba			o- 14. Race - Ameri White, etc.	can Indian, Black,
after der al". or i	by Fu	3 Widowed 4 Divorced of Yes 2 X No 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 Yes 2 X No specify:			Specify: Black	
72 hours		Elementary/Secondary (0-12) College (1-4 or 5+)	dent's Usual Decupa I most of working lif			16b. Kind of Business/	ndustry
OO36 within 'giene.	Completed	12th grade Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)					
1215- I be filed ental Hy rrked of	Be	Benjamin Bell		Betty B	easley	,	
MD 21215-0036 at 2 should be filed within 7 th and Mental Hygiene. a 27 is marked other than umatic event, the Medical	7					mber, City or Town, State re, Maryland	
Ore,   ges   and of Healt : If item	l,i	1 Burial 2 X Cremation 3 Removal from State crematory or			Date	20c. Location - City or	
Baltimore, permit. Pages I an Department of Hea Important: If iter	13		Int Cemete 2. Name and Addres		27/11 tman_Ha	Baltimore,	
m agaiii Physician	4	23a. Prt I. Enter the disease, or complications that caused the death. Do not enter	40 VETSTE	STOCOMII IV	<u>u Baltı</u>	more,Maryla	nd 21 21 5 Approximate Interval
/Medical	_	failure. List, nly one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wounds		,, ода, со од од од	, roopilatory at	root, orroot, or root.	Between Onset and Death
art <sup>d</sup>		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.					
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated					
ecuted and - transit		events resulting in death) Last Due to (or as a consequence of):					
cian cial	adical	UNPENDED AMENDED					
Box 68760, e death certificate be ex the attending physician of for use as the burial	Physician/Medic	past 12 months?	Fetal death 3	Ectopic pregna	ancy	23d. Date of delivery  Month	/ Day Year
<b>6</b> 5 <b>9</b> 1	hysic	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown					)
Records, P.O. E The law requires that the c are has been signed by the	ξ	Part II. Other significant conditions contributing to death but not resulting in the	a underlying cause	given in Part I.		obacco use contribute to s 2 ✔ No 3 ☐ Prot	
of Vital Records, ag Physician: The law require this certificate has been simmeral director, page 2 should be	Completed			24a. Was	psy prior to d	y prior to completion of cause of	
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of Vital ling Physician: After this certif	To Be	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 FR/Outpatient	ent 3 DOA	Other <sub>4</sub> Nursir	ng Home 5		:
E # . \2		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of Injury FOUND: FOUND: Dec 16, 2011  28b. Time of FOUND: FOUND: 22120 hrs		ry 28c. Injury at Work?  1  Yes 2 ✓ No 28d. Describe how injury occurred Subject shot			
Division  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: /	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street			Location (Street and Number or Rural Route Number, City or Town, State)     State Avenue, Baltimore, MD		
o the Ho ithin 24 I o the Fu	Medical	29a. Certifier (Check only one)  2 Medical Examiner On the basis of examination and/or investign and manner stated.	curred at the time, or gation, in my opinio	date and place, and n, death occurred a	I due to the cau at the time, date	se(s) and manner as state and place, and due to the	e cause(s)
F3F8	₩	29b. Signature and title of certifier		se number		29d. Date signed (Mo. December 17, 20	
OGME		30. Name and addryss of person who completed cause of death (Item 23a)  Mary G. Ripple MD. Deputy Chief Medical Examiner 90	00 W. Baltimor	e Street Raltin	more MD 2	1223	
St Regist	ate	31. Date filed (Month, Day, Year) 32. Resisted's Signature	arke	,,			
	الند	Unit V U SVIL   / WAR CO. J.	Wille				

DHMH 17 Rev 1/2001 OCME 2006 ORIĞINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42024 1 - State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day 2011 Month Physician/ 20 -12:00PM Dec Elizabeth Maxine Eure Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🗶 F 236-54-0629 75 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ms 23a or 28a-f shomust be notified at Director 1 X Yes 2 No MD Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number Funeral 20904 USA 12325 New Hampshire Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. iral", or iten Examiner r Armed Force Black, White, etc. ş 1 Never Married 2 X Married Yes 2 X No filed within 72 hours after 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced "natural" Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. the Private Industry Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 27 is marked of traumatic eventual Mental ည Margaret Wicks William Humphrey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 Brummel Court 100 12 19a. Informant's Name/Relationship (Type, Print) Timothy Eure/Son 20a. Method of Disposition
1 □ Burial 2 ★ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any Injury or o Chesapeake Crematory 1/3/12 Beltsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Austin ROyster Funeral Home Signature of Funeral Service Licensee mataco 3821 14th Street, NW, Wash, DC 20011 /M00969 100r 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician/ Myocardial Infarction Medical resulting in death) Due to (or as a consequence of) **Examiner** Myocardiopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to for as a consuluence of Atherosclerotic Heart Disease burial-trar physician sthe burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p for use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Live Birth 2 Live Fetal uses.

Pregnant at time of death Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown ed by the detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔼 Unknown Division of Vital Records, CHronic Renal Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner?

1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation within 24 hours after death To the Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Note: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of c 960 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe

State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

MD

31. Date filed (Month, Day, Year) JAN 0 3 2012

10810 Darnestown Road, #202, Gaithersburg,

20878

	Box 68760
ANN ETZEL	Records, P.O.
	of Vital
	vision

			Pleas	e Type or Pri				-	-	
		-	For State Registrar	State of M	aryland / Depa <i>Cer</i>	artment of H <i>tificate of D</i>			iene 2 (	011 42025
	Physicia Medic	al	1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. T						3. Time of Death 9:28 A M	
	Examin		4a. Facility Name (if not institution, give street and number)  Stella Maris  4b. City, Town, or Location of Death Timonium					4c. County Balti	of Death <b>Lmore</b>	
	Funeral Director		5. Social Security Number 213-40-2209  Usual Residence of Decedent  7. Age (In yrs. last birthday) 1 Usual Residence of Decedent  7. Age (In yrs. last birthday) 1 Usual Residence of Decedent  7. Age (In yrs. last birthday) 1 Usual Residence of Decedent  7. Age (In yrs. last birthday) 1 Usual Residence of Decedent					1942	9. Birthplace (State or Foreign Country) Maryland	
	aryland a-f show fied at	ctor	10a. State 10b. County	imore	10c. City, Town or Loc	cation Parkville		·		10d. Inside City Limits 1 ☐ Yes 2X☐ No
	with the Mass 23a or 28aust be noti	Funeral Director	10e. Street and Number 3118 Texas Aven	ue		10f. Zip Code 21234		1	10g. Citizen of V	What Country?
336	s after death al", or item Examiner m	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent   Armed Forces? 1  Yes 2  If Yes, Give Year or Dates.	No I	Was Decedent of His f Yes, specify Cubar I ☐ Yes 2 X No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - American Indian, ck, White, etc. :: white
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4 or 5	(Give i	dent's Usual Occupa kind of work done d O NOT use retired) ay Tech		king		Business/Industry  Medical Center
Maryland 2	d be filed wii Mental Hygie arked other ttic event, tl	To Be (	12 17. Father's Name (First, Middle, Las John C. Etzel	<u>2</u>	Λ-Κ	ay recir	18. Mother's Nam	ne (First, Middle, N yan	flaiden Surnam	е)
	d 2 should alth and I alth alth alth alth alth alth alth alth		19a. Informant's Name/Relationship Karen Chesek-dau			ng Address (Street a				
Baltimore,	Page 1 and ment of He tant: If item		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	ecify)	Park	matory or other place Memorial	e) Dec.3	31,2011	Parkvi.	- City or Town, State lle, Maryland
Ball	Depart Import any in		21. Signature of Funeral Service Lice	ensee Nº Fardi	22 E 8	Name and Address Vans Fune 1800 Harfo	eral Char ord Road-	el and C Parkvill	Crematic e,Mary	on Services land 21234
	Physician and bhysician and bhysician and physician and sthe purial-transit	Examiner	23a. Part 1. Enter the disease, or or shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. LUNG CA Due to (or as  b. Due to (or as	e.	er the mode of dying	g, such as cardiac	or respiratory arre	ist,	Approximate Interval Between Onset and Death
O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burn	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗶 No 9 ☐ Unknown	4 Pregnant a	2 Fetal death 3 Lat time of death 5 L	Other (specify)			Me	ate of delivery onth Day Year
Js, P.	uires tha in signed uld be de	ed by	Part II. Other significant conditions	s contributing to death t	but not resulting in the L	inderlying cause giv	/en in Part I.			tribute to the cause of death?  3  Probably 4 Unknown
Records,	The law requires cate has theen significate page 2 should b							24a. Was a autops perfor 1  Yes	med?	Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
Vital	nysician; The iis certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗶 No	Hospital:	ient 2 🗆 ER/Outpatier	Othe	ace of Death (Che	ck only one)	anca 6 🕱 Oth	her (Specify) HOSPICE
on of \	inding Phy ath. r: After this	Certificate: T	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	28a. Date of inju (Month, Da	ry 28b. Time of	28c. Injury work	y at	28d. Describe ho		
Division	Hospital or Attendi 24 hours after death Funeral Director: A stely filled in by the f	Certif	3 Suicide 6 Could no 4 Homicide determin	28e. Place of Inj	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (St City or Town		ber or Rural Route Number,
	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	(Check 2 Medical Exa	hysician: To the best of aminer: On the basis of durse Practitioner: To the	examination and/or inves	tigation, in my opinic	on, death occurred	at the time, date an	nd place, and du	ue to the cause(s) and manner stated.
	To the within 2 To the comple		29b. Signature and the of certifier	Loy	-DNP, N	P 29c. License	e number	158	29d. Date signe	ed (Month, Day, Year)
	10/		30. Name and address of person wh		death (Item 23a) (Type, I		RD. TIM	IONIÚM, M	D 21093	3
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 3 2012		ar's Signature					
DU	MH 17 Rev 06-	2011								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 610 AM 12 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death OCH Raven Ba genest TIMORE Xe 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🕅 M 2 □ F 219-22-5312 Months Days Hours Min. Director 84 MD Usual Residence of Decedent 23a or 28a-f show within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U • S • A • Funeral 21239 1507 Winston Ave items 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black White etc. "natural", or i þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☐XNo Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry Kennedy Krieger (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) 2yrs Elementary/Seconday (0-12) Institute Supervisor 12th grade jed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertie Mae Blount and 2 should be i Phillip Frazier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1507 Winston Ave, Baltimore, Md 21239 Health a Nancy Frazier-Wife permit. Page 1 and 2 Department of Health Important: If Item 2: any Injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Garrison Forest Vet 1/5/2012 Owings Mills, Md 21. Signature of Funer ervice Lice 22. Name and Address of Facility. 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 120 disease or condition resulting in death) Medical Due to (or as a consequéry e of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year signed by the a d be detached f g Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 2 110 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

3 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1335 Physician/ horalf tinkelser 31 2011 12 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Howard County General If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year, 1**X** M 2 □ F 114-03-4519 93 Director Aug 7 1918 Norway Usual Residence of Deceder 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director notified MD Howard Columbia 1 Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 ms 23a or Funeral 5400 Light House Court 21044 USA items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian Was Decedent Ever in U.S. Armed Forces?

1 □ XYes 2 □ No WWII If Yes, Give Year or Dates. "natural", or ite þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Completed th and Mental Hygiene. 27 is marked other than "natul traumatic event, the Medical 16b. Kind of Business/Industry Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Dredging Captain Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sophie Vatnestrom Sevrin Finkelsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Mrs. Gertrude Finkelsen (spouse) 5400 Light House Ct., Columbia, MD 21044 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 1-2-12 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Flugi Spright Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final astrointestinal Privalcian/ Unknowr disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Winknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 FR/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 1 Natural 8c. Injury at 28d. Describe how injury occurred After injury 5 Pending work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Aft
ad in by the fur Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after To the Funeral Directory City or Town, State) Medical 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 31, 2011 MO 8053312 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michelle Hengseler, MO 5755

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year,

Cedar lane, Columbia, MO 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 28,2011 7:25 A M Fisher Russell Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Owings Mills 118 Wilgate Rd. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** XXM 2 D F May 23, Year) 958 Hours England 217-86-4269 53 **Director** Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes XXNo Baltimore Owings Mills MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral England 21117 118 Wilgate Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes XX No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: 3 Widowed XXDivorced If Yes, Give White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than " Interior Elementary/Seconday (0-12) College (1-4 or 5+) Decorating Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosemary Jacobs Ted Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 st Department of Health ar Important: If Item 27 is any injury or other trau 118 Wilgate Rd. Owings Mills, MD 21117 Tony Fisher / Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
All Faiths
ematory & Chapel 12/30/11 Burial XXCremation 3 Removal from State 4 Donation 5 Other (Specify) Manchester, MD 22. Name and Address of FacilityEckhardt Funeral Chapel P.A. 21. Signature of Ingla Se ce License 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. SINUSINS Immediate Cause (Final disease or condition resulting in death) Physician/ months Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if ny timm cause. Enter Underlying Examiner and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury MONT that initiated events resulting in death) Last burial-1 attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Por Month Day Year 5 Other (specify) should be detached the g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed After this certificate has page 2 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ၉ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VEN O EUZ 31. Date filed (Month, Day, Year) 82 Begistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sharon Lee Fitzhugh 28, 2011 8:50 A M December Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death County of Death **Examiner** Montgomery Rockville Montgomery Hospice Casey House 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 215-66-8226 **Director** 1 🗌 M 2 🕱 F 57 January 25, 1954 Washington, D.C. Yrs Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits items 23a or 28a-f sho ler must be notified at 10c City Town or Location Director Gaithersburg Maryland Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral United States 20878 205 Twisted Stalk Drive death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian 11. Marital Status the Medical Examiner Armed Forces? Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after White If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 'natural". 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry giene. er than life DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) Law Firm Conflict Coordinator l Hygie Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file h and Mental H 7 is marked of မ Margaret Ann Burton Howard Lee Fitzhugh, Jr. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is. 2800 Quebec Street, NW, Washington, D.C. 20008 Darryl L. Fitzhugh/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January 5, cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Montgomery Crematorium, Bethesda, Maryland 4 Donation 5 Other (Specify) Inc. 2012 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licenses Ro M01498 KAR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Malignant Melanoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Exami Due to (or as a consequence of) physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 the as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 X No Day Year Month the 9 Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a. Was an autopsy performed? Yes 2 No has page 2 certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospice Inpatient Other: 4 Nursing Home 5 Residence 2 🔀 No 은 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending I Director: A ed in by the f Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined hours after within 24 hours a

To the Funeral E

completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Kertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tiple of certifie 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar

DHMH 17 Rev 06-2011

Deborah Miller, CRNP, 6001 Muncaster Mill Road, Rockville, Maryland 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registraris Signature

31. Date filed (Month, Day, Year

JAN 0 3 2012

R143201

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ rank December 6:50 PM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Glen Meadows Glen Arm Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F (Month, Day, Year) av 29, 1924 Months Davs Hours Min. 220-18-9035 Mary Land **Director** 87 May Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Baltimore Glen Arm 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral Apt 313 U.S.A. 11630 Glen Arm Road 21057 should be filed within 72 hours after death w and Mental Hygiene. is marked other than "natural", or items: 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Director Data Processing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Compton Guv R. Pauline Suresch 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Freeland, Maryland 21053 James E. Franklin S<sub>O</sub>n 21626 Parker Road or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 🕅 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Moreland Mem. Park 1-7-2012 Maryland 21. Signatur, of Foxeral Service Dicensee Ruck Towson Funeral Home, Inc. 22. Name and Address of Facility 21204 Towson, Maryland 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician Medical resulting in death) o (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death Month Year signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2**√** No 3 Probably 4 Unknown 1 Tyes been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has page 2 autopsy perform this certificate 1 ☐ Yes 2 ☐ No Yes 2 X 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🔀 Nursing Home 5 🗌 Residence 6 🗌 Other (Specify) 1 Tyes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? After 28d. Describe how injury occurred 1 K Natural 5 Pending To the Hospital or Attendin within 24 hours after death. To the Funeral Director; Aft 1 🗌 Yes 2 🗆 No Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nd title of certifie 29b. Signature

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month→Dav: Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 19a, b Per fit 1923 1 3 112 avt. State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 07:34 PM 22 22 Charlotte Gray December 2011 . Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital 01 Baltimore Ballmore Social Security Number Date of Birth If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year) **Director** 212-46-2746 68 1 🗌 M 2 🛣 F 12 26 42 MD Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director 1X Yes 2 No MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 21215 U.S.A. 3013 Spaulding Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 X Married Maryland 21215-0036 Black If Yes Give 1 ☐ Yes 2 ☐XNo Specify: Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Baltimore City na School Bus Driver and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) vermit. Page 1 and 2 should be a Department of Health and Mental Important: If Item 27 is meany injury or other Lucille Haycock Norman Campbell a. Informant's Name/Relationship (Type, Print)

John Gray— husband,

amela Thibldo Nie 195 Weiling Address (Stratend Number of Rural Route Number, City of Town, State, Zip Code)
5928 Charnwood Road, Catonsville, Md 21215 Md 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 🗌 Cremation 3 🗆 Removal from State Donation 5 - Other (Specify) Arbutus Memorial 12/30/2011 Arbutus, Signature of Funeral Service Licenses March Afren West 4300 Wabash Ave, 21215 Baltimore, Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final a. Chronic Physician/ obstructive disease or condition resulting in death) pulmonary disease days Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of heart foulure Congestive autopsy death? Diabetes melletus 1 ☐ Yes 2 ✓ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) Namita MBBS RES - 000 December 22. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Singh Namita MBBS Hospital Sinai Balkmore JAN 0 3 2012 32. Registrar's Signature State Registrar

Charlotte

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KNO CON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Augusto Quintela Guerreiro Gois 2011 6:00 A M December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery 6100 Maiden Lane Bethesda 8. Date of Birth (Month, Day, Year) Oct 17, 1934 **Funeral** Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 X M 2 □ F Hours Portugal 577-94-8075 **Director** Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours and 2 should be filed within 72 hours and 23a or 28a-f shown than the file of 1 is marked other than "natural", or items 23a or 28a-f shown thant. If item 27 is marked other than "natural", or items 23a or 28a-f shown than the file of 1 is a fire 10b. County 10a. State 10c. City, Town or Location Director MD Montgomery Bethesda 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 USA 6100 Maiden Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Yes 2 X No Yes, Give چ ک 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) International Elementary/Seconday (0-12) College (1-4 or 5+) Organization Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alirio Gois Isolina Leitao 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6100 Maiden Lane Bethesda, MD 20817 Elisa Gois/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important; If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 12/31/11 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Malignant Carcinoid Tumor of the Cecum disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of; If any, leading to increase cause. Enter Underlying Cause (Disease or iinjury that initiated events as the burial-trans Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 9 Unknown detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 Yes 2 No 3 Probably 4 No Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? Yes 2X No Director: After this certificate To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other:  $_4$   $\square$  Nursing Home  $_5$  X Residence  $_6$   $\square$  Other (Specify) 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A 2 🗆 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date filed (Month, Day, Year) -

IAN O

DHMH 17 Rev 7/2009

Coleman, M.D. 1355 Piccard Drive Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D37142

December 31, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Vear Marie Garrity Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8584 Valley Drive Middletown Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Min Hours Director 148-03-0024 1 M 2 X F 92 Aug 30, 1919 New Jersev Usual Residence of Deced 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🎛 No Maryland Frederick Middletown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 8584 Valley Drive 21769 United States items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Medical Examiner Armed Forces? Black, White, etc. 5 þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygien Important: If item 27 is marked other th any injury or other traumatic executions. 12 Unknown Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Michael Trembulak Mary Pavlova 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8584 Valley Drive Middletown, MD 21769 Robert Garrity / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 1/3/2012 Woodbine, Maryland . Signatur Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 -MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final et and Death Physician. disease or condition DEDMARY leac Medical resulting in death) Due to (or as a consequence of): Examiner Facused in the state of the sta Examiner Due to (or as a consequence of) use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last iding physician and Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter in the past 12 months?

1 Yes 2 No

9 Unknown Month Day Year signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed 1 Yes 2 🗌 No funeral director, 25. Was case referred to medica Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 🗌 Nursing Home 5 🕅 Residence 6 🗌 Other (Specify) ဂ္ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of De th Certificate: 1 Natural 28b. Time of 28c. Injury at injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei (Check 3 🗆 only one 29b. Signature and the of certifier 29c. License numbe

completely filled in by the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 32. Re State JAN O Registrar ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Karen Lee Guralecz		e of Maryland / Depa Ce		Health and		giene	20	11 4203
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,L			-l-o	į.	. Date of Death	Day Vear	3. Time of Death
Miedical Examiner	4a. Facility Name (if not institution, of 115 Reider Court Apt. A	give street and number)		4b. City, Town, or L Edgewood		December	4c. County of De Harford	
Funeral Director	215-60-4718	Sex 7. Age (In yrs. I	ast birthday)  57  Yrs	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth <b>MAR</b> 13	1954	Birthplace (State or eign Country) <b>Maryland</b>
Maryland 28s-f show any d at once.	Usual Residence of Decedent  10a. State 10b. County  MD Har	ford 10c. City,	Town or Locati	en Edgewo	od			10d. Inside City Limits 1 Yes 2 No
the Maryland a or 28s-f sh- tified at once	10e. Street and Number 115 Reider Cour	t, Apt. A		10f. Zip Code	040	10	g. Citizen of What C USA	ountry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "satural", or items 23s or 28s-f shot injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 X Divorce	12. Was Decedent Ever in U Armed Forces? 1  Yes 2 No ed If Yes, Give Year or Dates:	lf Y	s Decedent of Hisp es, specify Cuban, Yes 2 X No	Mexican, Puerto R		White, etc	erican Indian, Black,
"natur	15. Decedent's Education (Specify Elementary/Secondary (0-12)			t's Usual Occupationst of working life. I			16b. Kind of Busines	ss/Industry
5-0036 ed within 72 houn bygiene. other than "natu the Medical Exam		2	Custon	er Servi				ales Store
215-C be filed v ntal Hygi rked oth ent, the Be Co	17. Father's Name (First, Middle, La <b>John</b> M	·	stead	118	8.Mother's Name (I Natal:			oward
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygienc. m 27 is marked other than aumatic event, the Medica To Be Comple	19a. Informant's Name/Relationship  Mindy L. Guralec	(Type, Print)	19b. Mailing		and Number or Ru	ral Route Numb	per, City or Town, St	ate, Zip Code)
re, M 1 and 2 Health ritem 2	20a. Method of Disposition	20b.		Chape1gate ition (Name of cemo		Date	amp, MD 20c. Location - City	21017 or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	1 Burial 2 X Cremation 4 Donation 5 Other Spec	ity: Me	tro Cre	matory, 1			Baltimo	
Ball permit Depart Impor injury	21. Signature of Funeral Service Lic	ensee orge MacNa	11556	lame and Address of 299 Frede	<sup>of Facility</sup> Crer erick Roa	nation d Ralt	Society o	f MD, Inc. 21228
Physician /Medical Examiner	23a. Part I. Enter the disease, or con failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)		. Do not enter th					Approximate Interval Between Onset and Death
red nsit <b>Examiner</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a consequence of c.  Due to (or as a consequence of consequence						
e executed cian and irransit dical Ex	UNPENDED	d			-			
Dox 68760, the death certificate be early early sicial by the artending physicial ched for use as the buriar Physician/Medii	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg	2 Fe	tal death 3	Ectopic pregnand	Э	23d. Date of deliv	ery Day Year
Box e death of the atter red for us	1 Yes 2 V No 9 Unkno	Wn 9 Unknown	□ Oti	ner (Specify)	,			
s, P.O. iires that the signed by d be detach	Part II. Other significant condition	s contributing to death but not r	esulting in the u	inderlying cause giv	ven in Part I.		acco use contribute 2 ✓ No 3 ☐ P	to the cause of death?
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buriledical Certification: To Be Completed by Physician/Med					_	24a. Was an autops perform	y prior t ned? death	autopsy findings available o completion of cause of ? Yes 2 No
f Vital Physician: or this certical director To Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient		of Death (Check on Other Nursing		Residence 6 🗹 Ot	ner: Scene
ion of tending Pteath.  tor: After the funeral	27. Manner of Death  1 Natural 5 Pending 2 Accident Investig		28b. Time of In FOUND: 1057 hrs			8d. Describe ho ubject hung	ow injury occurred self	
Division o  To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	3 Suicide 6 Could n 4 Homicide	ot be 28e. Place of Injury - At h		et, factory, office bu		or Town, Sta		Rural Route Number, City ood, MD
To the How within 24 h To the Fun completely	1017001 U.N.	Ician: To the best of my knowled ner: On the basis of examination a and manner stated.						
Tr. Soo	29b. Signature and title of certifier	Speed 2080	2	29c. License O.C.M			29d. Date signed (I	
	30. Name and address of person whictor Weedn MD JD	o completed cause of death (Item Assistant Medical Exami		/. Baltimore Str	reet. Baltimore	. MD 2122	3	
State Registrar	¥ 79_	2012 32. R gistrar's Signatu	ure:	e Med			-	

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 December 5:44 James Guercio Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center Towson If Under Birthplace (State or Foreign Country) 5. Social Security Numbe 8. Date of Birth 7. Age (In yrs. last birthday) Year If Under 24 Hrs. **Funeral** Months Days Hours (Month, Day, Year) 213-20-9879 1 X M 2 🗆 F Director 84 Sept. 27,1927 Maryland Usual Residence of Deceden 28a-f show at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 6609 Rannoch Drive 21228 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian the Medical Examiner Rlack. White, etc. 1 Never Married 2 X Married "natural", or þ 1 Ty Yes 2 I If Yes, Give Year or Dates 2 No within 72 hours after Saltimore, Maryland 21215-0036 1 Tes 2 No Specify 3 Widowed 4 Divorced White WWTT Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) W.R. Grace E<u>lectrician</u> event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o permit. Page 1 and 2 should be 1 Department of Health and Menta. Important: If item 27 is marked any injury or other traumatic eve 2 Joseph Guercio Elsie Mattingly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Berwager/Daughter 6609 Rannoch Drive, Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Metro Crematory Inc. 12/30/2011 | Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician t wecks disease or condition ) Medical resulting in death) to (or as a consequence of) Examine mentra LAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due for use as the burial-transi Cause (Disease or injury b that initiated events resulting in death) Last and attending physician Physician/Medical certificate be P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the ar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 3e. Did tobacco use contribute to the cause of death? 9 2 No 3 ☐ Probably 4 ☐ Unknown Records, 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy performed? Yes 2 No After this certificate has • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific funeral director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NO3 (A.C. ၉ 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending Fall from Standing work? 1 ☐ Yes 2 ☑ No 2 Accident Investigation December 17 dal evening filled in by the 6 Could not be 28e. Place of Injury - At home, farm, swal, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ASSISTED LIVING FACILITY 7110 minskel way, columbia MD Medical 29a. Certifie Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 L 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number December 29 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 No Chanks

DHMH 17 Rev 06-2011

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Registrar

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Year)

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AMRON 31. Date filed (Month, Day, M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Paul Joseph Gerhardt 6:35 A December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** Days Hours Maryland 213-68-0402 Director 1 🗶 M 2 🗆 F October 6,1956 55 Usual Residence of Decedent ral", or items 23a or 28a-f shorex examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1XX Yes 2 ☐ No Maryland n/a **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3804 Echodale Ave. United States 21206 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 No Specify: Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) cemetery sales representative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Rita Catherine Kraft Charles Grayson Gerhardt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Ellen Gerhardt/wife Baltimore, MD 3804 Echodale Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2  $\square$  Cremation 3  $\square$  Removal from State Dulaney Valley Mem GardJan. 3,2012 | Timonium, Maryland 4 Donation 5 Other (Specify) John O. Mitchel Pity, Funeral Services of Dulaney Valley, Timeral MD 21093 P.A. Signature of Funeral Service Licenses Mit Timonium, MD 200 E. Padonia Rd. 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MCTERTIA disease or condition Medical resulting in death) to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached fo 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence  $\bigcirc$  Other (Specify) W S  $\mathcal M$   $\mathcal U$ 1 🗌 Yes 2X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1/2 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add untles Tovison MA OHARLRI WM) 6201 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day 2011 Physician/ 31 5:25 AM Lawrence Stephan Glick Dec. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Westminster Carroll Hospice Dove House Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 MM 2 1 F Hours 11 1 1 6 7 1 9 5 9 52 Director 219-74-0732 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Carroll Westminster MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 USA 712 Winchester Drive 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian þ 1 Never Married 2 Married Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Management/Owner Carpet Cleaning 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lois Bratman Morris Jacob Glick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Cedar Point Dr. Perryville, MD Robin G. Baum-Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 Burial 2 Cremation 3 Removal from State Sykesville South Carroll Crem 1/1/12 4 Donation 5 Other (Specify) . Sonatur of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home, P.A 254 E. Main ST. Westminster, MD 21157 Westminster, MD Main ST. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or illinging that initiated events Due to (or as a consequence of) burial-trar resulting in death) Last Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) g 🗍 Unknown g Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 4 Unknown Completed 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No this certificate 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Natural Accident 5 Pending injury Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

State

32. Registrar's Registrar

29b. Signature and title of certifier

who completed cause of death (Item 23a) Type, Print

29c. License number

29d. Date signed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 42038 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Carlo Griguolo December 31<sup>y</sup>,2011<sup>ear</sup> 11:50A. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Balto. Gilchrist Towson Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) Social Security Number 1 Year If Under 24 Hrs. **Funeral** Hours Director 1 M 2 D F 214-40-2969 82 March 12,1929 Italy Yrs Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director Md. 1 X Yes 2 No Baltimore 10e Street and Number 10f. Zip Code 0 10g. Citizen of What Country? must be Funeral 23a 4618 Charles Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. ò ģ 1 Never Married 2x Married filed within 72 hours after Maryland 21215-0036 1 Yes 2X No Specify: White Specify: 3 Widowed 4 Divorced "natural" Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Self-Employed Shoe Repairman 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I ပ Salvatore Griguolo Guiseppina Marinelli Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau DTR. Rosa A. Ziolkowski Parkville, Md. 21234 3004 Edgewood Avenue Baltimore, 20a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley 1-3-2012 Timonium, Md. 22. Name and Address of Facility Schimunek Funeral Home, Inc. Signature of Funeral Service L 9705 Belair Road Nottingham, Md. 23a. Pari 1. Enter the disease, or complications that saused shock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PREPROVASCULAK disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of and burial-tran Due to (or as a consequence of): resulting in death) Last ding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be e 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, VASCULAR 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an page 2 prior to completion of cause of death? performed Yes 2 ₹ 2 No 1 Yes Division of Vital the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 ... 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 30. Name and address of person who com leted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year 22. Registrar's Signature State JAN 0 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 42039 State of Maryland / Department of Health and Mental Hygiene 2 () For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Clarence E. Glenn 29,2011 6:05A December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death **Examiner** Howard Gilchrist Columbia Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Hours Min 422-16-8763 **Director** 1 XM 2 - F 9-25-1921 Alabama 90 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Howard Ellicott City Md. 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21042 5330 Dorsey Run Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. White 3 Widowed 4 Divorced Completed Year or Dates.1942-1946 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Post Office Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary E. Campbell Walter L. Glenn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6715 Hitching Post Ct. Clarkville, Md. 21029 Joan E. Huether StepDaughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-5-2012 Parkville, Md. Parkwood Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek FuneralHome, Inc. 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Bladder disease or condition resulting in death) lear Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events the burial-tra Due to (or as a consequence of) resulting in death) Last physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as t attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No for Month Year Pregnant at time of death detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death?
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3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 17 Rev 06-2011

BINDU.

31. Date filed (Month, Day, Year)

JAN 0

JOSEPH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336

CEPAR

32. Registrar's Signature

00060634

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COLUMBIA

2601 0 1/8/151 Groves, Paul

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Funeral Director		5. Social Security Number 6. Sex 7. Age	9. Birthplace (State or Foreign Country)							
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with the s 23a or tust be r	Funeral D	10e. Street and Number 13111 Ardennes Avenue		10f. Zip Code 20851			og. Citizen of Wh J <b>nited</b> S			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent E Armed Forces?  1 Never 2 If Yes, Give Year or Dates.		<ul><li>13. Was Decedent of Hilf Yes, specify Cuba</li><li>1 ☐ Yes 2 X No</li></ul>	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, White, etc. White		
thin 72 hour ne. than "natui he Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5	16a. De	ecedent's Usual Occupa ive kind of work done d e. DO NOT use retired) Firefight	uring most of worki	ng	6b. Kind of Busin	ness/Industry		
l be filed wir fental Hygie rked other tic event, tt	To Be C	12 17. Father's Name (First, Middle, Last) Carl Gruver		riferight		e (First, Middle, Ma		<u> </u>		
12 should	·	19a. Informant's Name/Relationship (Type, Print)  Lynda A. Gruver/Wife		lailing Address (Street a						
Page 1 and ment of Hez ant: If item ury or othe	1	20a. Method of Disposition 1 □ Burial 2 🎇 Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemetery, c	sposition (Name of crematory or other place ry Crematoriu	e) Janua	ary l,		ity or Town, State		
permit. Depart Import any inj		21. Signature of Funeral Service Licensee	MO1173	22. Name and Addres Robert A. Pi 300 W. Mont	s of Facility Limphrey Fur gomery Aver	neral Home, nue, Rockv	Rockvill	le, Inc. yland 20850		
Physician/	23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Medical Examiner		Shock	c nsequence of):	/						
ecuted and -transit	xaminer	Gause (Disease or injury that initiated events	consequence of:	loss an	emir					
te be exe hysician a the burial-	dical E	resulting in death) Last  Due to (or as a death) Last  d	gasto i	ntestimal	bired	,				
Attending Physician: The law requires that the death certificate be exerged early state of the s	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome c 1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	У		23d. Date Montl			
ires that the signed by	þ	Part II. Other significant conditions contributing to death be hypo tension			en in Part I.			oute to the cause of death?		
ie law requ e has beer age 2 shou	Completed	non ST elevated myocal	irdial ir	farction 1		24a. Was an autopsy perform	ed? de	ere autopsy findings available for to completion of cause of aath?		
cian; The ertificat	Be	25. Was case referred to medical examiner?	37.00 4 0	26. Pla	ace of Death (Checi	1  Yes 2 k only one)	No 1L	Yes 2 No		
g Physi er this c ieral dir	e: <b>T</b> o	27. Manner of Death 28a. Date of injur	ent 2 ER/Outpa y 28b. Time ( Year) injur	e of 28c. Injury	4 ☐ Nursing Ho  at	ome 5 Residen 28d. Describe how				
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certificate:	1 Matural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Inju		Yes 2 No	28f. Location (Stre		or Rural Route Number,			
Hospital o	Medical C	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of examiner)	my knowledge, dea			nd due to the caus	se(s) and manner			
To the twithin 2. To the F	Me	only one) 3 Certifying Nurse Practitioner: To the 29b. Signature and title of certifier	best of my knowled	dge, death occurred at the 29c. License	ne time, date and pla number	ace, and due to the	cause(s) and mar	nner as stated. "Month, Day, Year)		
		30. Name and address of person who completed cause of de ma hammed Mehmood, Po	eath (Item 23a) (Tvo	pe, Print)	12143		recemb	1431,2011		
ĺ		mohammed Mehmood, Do	9901 A	nedical ce	nter Dr	ive, Rock	M/2/11W	landone 20550		

State Registrar 31. Date filed (Month, Day, Year) JAN 0 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER Day 20 Grove XIZanne 2011 0:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE WASHINGTON MEDICAL ANNE ARUNAEL FUTER GLEN BURNIE | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | 1 | 1 | 1 | 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F 216 68 8059 54 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD Anne Arundel Pasadena ò 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7723 Middlegate Court 21122 U.S.A. items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14 Race - American Indian Armed Force Black, White, etc. 2 þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", 3 Divorced 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) SUZANDE permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mery injury or other traumatic event. College (1-4 or 5+) 12 Sewing Machine Operator Bookbinding Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elwood Frank Miller Bernardine Brandt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7723 Middlegate Ct Pasadena, MD 21122 Timothy Grove - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lorraine Park Cem 12/23/11 Woodlawn, <sup>22. Name and Address of Facility</sup> GJ Gonce Funeral Home, PA 169 Riviera Drive Pasadena, MD 21122 Signature of Euperal Licensee 23a. Part 1, Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Shoc Medical resulting in death) Examiner Sequentially list conditions, Examine if any leading to immulace cause. Enter Underlying Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death the g Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? Š Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate Yes 2 N 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Unpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu 29d, Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Himore ashinsten 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2012 Registrar JAN 0 H DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 12<sup>Month</sup> Physician/ 2011 7:00 21 Ам **CLARA** THELMA GANNON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8140 Jade Crossing Court Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Min Hours 216 20 2939 85 **Director** 1 🗆 M 2 🔀 F 04 14 1926 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at with the Maryland **Funeral Director** 1 Yes 2 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be 23a 21228 U.S.A. Apt. 1 Winesap Ct. Ε items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ō by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2. No Specify: Specify. "natural" Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) the Secretary Citicorp of Health and Mental Hygie If item 27 is marked other ir other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Gertrude Elizabeth Schneider Edward Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 21122 Thomas Gannon - Son 8140 Jade Crossing Ct Pasadena, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 12/27/11 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility GJ Gonce Funeral Home 21. Signature of Funeral Service Licensee 169 Riviera Drive Pasadena, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Set and Death Immediate Cause (Final Physician/ UNG disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause in the conditions (Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending inhusinia Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year signed by the at Id be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 Ves 2 No Yes 2 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Son's Home 2 No ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 5 Pending work 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or invastigation. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse gractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) IIM ompleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death MESM 9. Physician/ Q.M Harris Arthell Medical (if not institution. 4c. County of Death Examiner Location of Death MOY If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 4M 2 F Days Min (Month, Day, Year) Months Hours Yrs **Director** 60 500-46-0350 28a-f shov 10a. State 10b. County 10d. Inside City Limits at 10c. City, Town or Location Director Examiner must be notified 1X Yes 2 No MIC NA Baltimore 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21216 U.S.A. 2555 Harlem Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 0 à 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ X\lo If Yes, Give Year or Dates. Maryland 21215-0036 U.S.A. 1 Yes 2 XNo Specify: "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 and Mental Hygiene. life. DO NOT use retired) lementary/Seconday (0-12) College (1-4 or 5+) Computer Company 12th grade Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic even Lucinda Harris John Walker Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md 21216 2555 Harlem Ave, Baltimore, <u>Ramona Harris-Wife</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 1/3/2012 Woodlawn, Md 4 Donation 5 Other (Specify) Woodlawn of Funeral Service Licensee Signatur Marcharty not west 21215 Baltimore, Md 4300 Wabash Ave, 23a. Par 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. dethe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ Fib 20 muin disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Morrin Sequentially list conditions, ner Due to (or as a consequence of): if any, leading to immediate Examir death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Dav been signed by the should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an To the Hospital or Attending Physician: The law page 2 s performed? Yes 2 certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **X** No Certificate: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of s after death.

I Director: After to in by the funeral 28c. Injury at 28d. Describe how injury occurred 1 🙇 Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined filled in within 24 hours a

To the Funeral D

completed filled is Medical 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) 0 12 H72243

State Registrar 900 Socaton Ave,

32. Registrar's Signature

Baltimore, MD 2/229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Honus

31. Date filed Month, Day, Year)

JAN 0 3 2012

Sharon	Yvonne	Hubbard
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		- For State egistrar	Certifica	Reg	Reg. No.				
Physician	1/	. Decedent's Name (First, Middle,Last)	141100	Date of Death     Month	Day Year	3. Time of Death 1438 hrs			
Medical Examin		unaron yvon	ne riubbara	In on The Last to A Death	December 2	26, 2011 4c. County of Death			
	4	la. Facility Name (if not institution, give 3922 Lumo Circle	street and number)	4b. City, Town, or Location of Death Randallstown		Baltimore County			
Funeral Director		247.15.3413 10	Months Days Hours Min.						
Maryland 28a-f show any d at once.	7	Jsual Residence of Decedent  10a. State  10b. County  Battin	10c. City, Town of Ra	ndallstown			10d. Inside City Limits		
th the Maryland 23a or 28a-f sho notified at once.	<u>ē</u>	3922 LUMO (	Cirde	10f. Zip Code 21133	10g	Citizen of What Coul	ntry?		
er death wi		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No  Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto     Yes 2 \ No specify:		White, etc.	ican Indian, Black,		
036 ithin 72 hours and the control of the control o	Completed b	15. Decedent's Education (Specify onl Elementary/Secondary (0-12)	College (1-4 or 5+)	ecedent's Usual Occupation (Give kind of uring most of working life. DO NOT use ret	ired)	6b. Kind of Business/ Battimor			
MD 21215-0036 12 should be filed within 7 and Mental Hygiene. 127 is marked other than unatic event, the Medical	8	7. Father's Name (First, Middle, Last)  Robert Kelsec  9a. Informant's Name/Relationship (T	pe, Print ) 19b.	18.Mother's Name  Julia  Mailing Address (Street and Number or	e (First, Middle, Ma  V. 5	cner	ı, Zip Code)		
를 등 등 등	Ĺ		Jr. (Nusband) 3	922 LUMO CIFCLE Disposition (Name of cemetery,	Randa	Ustanh to 20c. Location - City or	1021133		
Baltimore, permit. Pages I a Department of He Important: If ite Important: If ite injury or other to		1 Burial 2 Cremation 3 Donation 5 Other Specify: 21. Signature of Funeral Service Licens	Bellev	ry or other place)  ille Mem. Gardens  22. Name and Address of Facility	07/2012	Orance by	urs, 30 11 20/50/65 11 120/50/65		
Physician	- 2	failure. List only one cause on eac	h line.	enter the mode of dying, such as cardiac of	or respiratory arres		Approximate Interval Between Onset and Death		
Examiner		or condition resulting in death)	Metabolic Acidosi	İs			Deau		
	iner	sequentially list conditions,  if any, leading to immediate  cause. Enter Underlying Cause	Liver Disease ue to (or as a consequence of):						
ecuted and - transit	EX	(Disease or injury that initiated events resulting in death) Last d.	ue to (or as a consequence of):						
ਰ ਜ਼ਿਜ਼ ਫ	Medical	X UNPENDED	AMENDED 23a-b, 27, pe	r me,g923 1-9-12 sm					
	Physician/Me	F FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 W Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregn	ancy	23d. Date of deliver Month	y Day Year		
P.O. By that the de need by the detached f	g P	Part II. Other significant conditions		in the underlying cause given in Part I.		acco use contribute to	the cause of death?		
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed				24a. Was ar autopsy	prior to death?	utopsy findings available completion of cause of		
Vital Recysician: The list certificate bidirector, page		25. Was case referred to medical		26.Place of Death (Check	1 Yes 2	No1 ✓ Y	es 2 No		
/ital	mσ		ospital: 1 Inpatient 2 ER/Ou			esidence 6 🗸 Othe	r: Scene		
on of nating Ph. Ith. After the funeral	2 : 10 100: 1	27. Manner of Death  1 X Natural 5 Pending	(Month, Day,Year)	ime of Injury 28c. Injury at Work?  1 Yes 2 No	28d. Describe ho	w injury occurred			
DIVISION pital or Attent ours after death teral Director: filled in by the	린	2 Accident Investigatio 3 Suicide 6 Could not be determined	28e Place of Injury - At home, far	rm, street, factory, office building, etc.	28f. Location (Str or Town, Sta		ural Route Number, City		
DIVISION To the Hospital or Attenution 24 hours after death within 24 hours after death To the Funeral Director. Completely filled in by the	लुं	one) 2 Medical Examiner:		th occurred at the time, date and place, and westigation, in my opinion, death occurred	at the time, date ar	nd place, and due to th	ne cause(s)		
8	¥	29b. Signature and title of certifier	00000	29c. License number O.C.M.E.		29d. Date signed (Mo December 27, 2			
5	-	30. Name and address of person who c Carol Allan, MD Assistar		V. Baltimore Street, Baltimore, N	ID 21223				
Sta Registr	~~	31. Date filed (Month, Day, Year)  JAN 0 3 2012	2/ Registrar's Signature	harles					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42047 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0855 W Dec. 31<sup>ty</sup>, 201<sup>th</sup> Robert Duncan Herzog, Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 402 Taylor Ave Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours (Month, Day, Year) 215-60-7505 **Director** 1 **X** M 2 □ F 49 Yrs Oct. 6, 1962 Washington, DC 28a-f show 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 □ No MD Montgomery Rockville 23a or 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 402 Taylor Ave. 20850 USA and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give þ Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 1982-88 marked other than "natur matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanical Engineer Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Patricia Schutt Robert Duncan Herzog, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Taylor Avenue Rockville, MD 20850 S Health tem 27 Audra Lynn Herzog/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 1/5/2012 Woodbine, Maryland 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eacly line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or injury that initiated events the attending physician and shed for use as the burial-tran-Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) q 🗌 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an completely filled in by the funeral director, page 2 autopsy performed? Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and that it is a stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one Signature and title of certifi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30, 2011 7:47 A M December Clarence Hart Medical 4a. Facility Name (if not institution, give street and number)
St. Thomas Moore Nursing &
Rehabilitation Center 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Hyattsville Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Mar 30 Hours 1952 Washington DC Director 215-60-9337 59 Yrs Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No DC Washington DC 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 311 Crittenden Street NW #4 20011 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 African American If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene.

is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) (unk) University Handy Man it. Page 1 and 2 should be filed w rtment of Health and Mental Hygi rtant; If item 27 is marked other jury or other traumatic event, it event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry Edwards Sarah Jane Bownes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4519 Tuckerman St. Riverdale Park, MD 20737 Virlene L. Myers / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 1/3/2012 Woodbine, Maryland 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death · Prugressive Multifical Leukusweephalopha Physician/ disease or condition wouths Medical resulting in death) Due to (or as a consequence of): Examiner ears b. Human Immurodeficiency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a Id be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Encophalopathy HERATITIS ( 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Pulmonary Tuberculasis 24a. Was an has autopsy performed? Yes 2 N this certificate 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 L Yes 2 KNo Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 XNursing Home 5 Residence 6 Other (Specify) After thi funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending 1 Natural work 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined edical

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after death.

<u>a</u> := <b>a</b> a a	Σ	only one) 3 — Certifying Nurse Practioner: 10 the best of my knowledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated.
vithin To the compl		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		Paul anlevore un	201852	DECEMBER \$1 20.
7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	sburg Rd Hatts	180 MD 20781
Stat Registra		31. Date filed (Month, Day, Year)  JAN 0 3 2012  32. Registrar's Signature.	es)	
H 17 Rev 7/20	09			

1🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29a. Certifier

(Check

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2011

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hoffmann 5:30 Edith  $P_M$ 2011 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 115 Donzen Drive, Apt. A Bel Air Harford Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) 319-26-5032 **Director** 1 🗆 M 2 💢 F 93 Aug. 17, 1918 Illinois Usual Residence of Decedent 28a-f show ms 23a or 28a-f shormust be notified at 10a. State 10c. City. Town or Location Director 1 Yes 2 X No Bel Air Harford Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 115 Donzen Drive, 21014 United States Apt. A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, an "natural", or itel Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ₹ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry المالك من المالك من المالك ال (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the School System should be filed with and Mental Hygier. 8 Cafeteria Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Frederick Goldt Doris Stockwell other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health an
Important; If item 27 is 134 Edmund Street, Aberdeen, Maryland 21001 Sandra D. Gooden/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Metro Crematory Inc. 12/30/2011 | Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between nset and Death Immediate Cause (Final ORONARY Artery Miscose Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Onderlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Pregnant at time of death 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🌠 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 **Y** No Other: 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 M Natural 5 Pending injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif December 30, 2011 39889 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MACPHAIL BE/ DIN MD 21014 DLAMA 5 PANUS 31. Date filed (Month, Day, Year) State Registrar

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State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AM 30 enneth Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Catonsville Commons Nursing Home Catonsville Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) 226-28-4748 **Director** 1 M 2 □ F 82 Virginia Usual Residence of Deced 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f MD **Baltimore** 1 🗌 Yes 2 🗶 No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 2209 Rockhaven Avenue 21228 **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, l Hygiene. Jother than "natural", or iter vent, the Medical Examiner Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 No
If Yes, Give
Year or Dates. 1950-52 þ Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10 College (1-4 or 5+) Truck Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 William Η. Hixon Mackie Moore t. Page 1 and 2 should be rtment of Health and Men rtant: If item 27 is marke njury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie T. Hixon, wife 2209 Rockhaven Avenue Catonsville, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Department of Important: If i any injury or conce. Metro Crematory, Inc. 12/30/11 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylian disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Universitying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami burial-transi and resulting in death) Last Due to (or as a consequence of) physician Physician/Medical certificate be P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death signed by the at d be detached for 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy perform death? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 1 25. Was case referred to medical Be 26. Place of Death Check only one) examiner? Hospital Other 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer 1 atural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 50725 mpleted cause of death (Item 23a) (Type, Print) water Colony D1. 2007 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 42051 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Himes PM DP 2011 Medical ecembe 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins 8. Date of Birth (Month, Day, Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 177-60-7186 1 M 2 F **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number ò 10g. Citizen of What Country? Funeral items 23a Valley Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or þ 1 ☐ Never Married 2 ☑ Married 1 NYes 2 □ No If Yes, Give / 48/ - / 485 Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Completed 3 Divorced 4 Divorced White uth and Mental Hygiene.
27 is marked other than "natur r traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, tate, ip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Se 22. Name and Address of Facility -Ashton Funeral Home oad 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final .Ph\_sician/ intoxication disease or condition Verapanul Medical resulting in death) Due to (or as a consequence of): Examiner DESTRICTION APPROVED BY MEDICAL EXAMINEM Sequentially list conditions, Examiner if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the burial-transi Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) been signed by the atter in the past 12 months? Month Dav Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 No certificate 1 🗆 Yes 2 🗆 No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No the Hospital or Attending Physician: Be 26. Place of Death (Check only one) n 24 hours after ceau.. he Funeral Director: After this ce toletely filled in by the funeral dire Hospital Other: မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗌 Natural injury 5 Pending work 29/11 1 Tes 2 No Accident
Suicide Investigation unknown subject ingested Verapai 6 Could not be Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined building, etc. (Specify) HOHE 4207 Valley Vicus Ave., Balminge, MD 21206 Medical within 24 hou

To the Funer

completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certific 29c. License number 9 December 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew JOBERHAM St Baltimore Maryland Stick IN COST

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month)

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year 11:00 P<sup>M</sup> NINA JOHNSON HAMILTON 08 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Min **Director** 1 🗆 M 2 🕱 F NONE 12/1/2011 Usual Residence of Decedent Maryland iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Forestville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3705 Monacco Court 20747 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married ☐ Yes 2 💢 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify "natural", 3 Widowed 4 Divorced Specify: Black Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jonte Hamilton Derrina Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jonte Hamilton/Father 3705 Monacco Court Forestville, MD 20747 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory12/13/2011 Alexandria, VA re of Fuperal Service Lice 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury -mp and that initiated events resulting in death) Last as the burial attending physiciar Physician/Medical or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ NO Month Day Year Pregnant at time of death signed by the ar P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page performed Yes 2 No 2 No 1 Tes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' ပ 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. I Director: After t 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending the Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Hospital 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier

To the I within 2. Registrar

DHMH 17 Rev 06-2011

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

JAN 0 3 2012

30. Name and address of person who completed cause of death

300

Ctoc

29d. Date signed (Month, Day, Year)

8

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RICHARD NEAL HARMON 2011 December 30 4:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months **Director** 214-36-8645 1 🔀 M 2 🗆 F June 4, 1940 Maryland 71 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes XX No MD Anne Arundel Jessup 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 2852 Jessup Road 20794 death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1962 ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 nan "natural", o If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: 1968 Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the 12th Pet Grooming Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nit. Page 1 and 2 should be filer artment of Health and Mental H ortant: If Item 27 is marked of ဂ္ Robert D. Harmon Miriam V. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon L. Harmon/Wife 2852 Jessup Road, Jessup, MD 20794 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o cemetery, crematory or other place. 1 Burial 2 Kremation 3 Removal from State 4 Donation 5 Cther (Specify) West Arundel Crem. 12/31/2011 Odenton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sause on each line. 23a. Part 1/ Enter the disease, or complica Approximate , or neart failure. List only one Interval Between Cause (Final Onset and Death Ph sician/ cel Carcinoma disease or condition rpans Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last burial physician s the burial Physician/Medical P.O. Box 68760 attending p IF FEMALE yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Dav Year 1 Yes 2 L 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has the director, page 2 s autopsy performed' Yes 2 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 IDOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUSERH CEDAR LANE COLUMBIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 27,201 Tar 9:55P William Alfred Hurlock, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balto. Parkville Oakcrest Village 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours 12-14-1928 Maryland **Director** 83 213-26-6181 Usual Residence of Decedent or 28a-f shown notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Parkville Balto. Md. 1 Yes 2 X No Apt. 321Pf. Zip Code 10e. Street and Number 10g. Citizen of What Country? iral", or items 23a o Funeral 21234 USA Lark; s Landing 8832 Walther Blvd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. Š 1 Never Married 2 X Married White 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Balto. Gas & Electric Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) ၉ edna R. Smith Rufus T. Hurlock, Sr. Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2985 Elkridge Lane York,Pa. 17404 william A. Hurlock, Jr. Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🛣 Burial 2 □ Cremation 3 □ Removal from State 12-31-2011 Donation 5 Other (Specify) Lorraine Park Schimunek Funeral Home, Inc. ignatur Service Licenses 22. Name and Address of Facility 9705 Belair Road Nottingham, Md. 21236 rt 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate \* Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Congestive Cardi Medical resulting in death) Due w (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to jor as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes Records, 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed Yes 2 page 2 certificate Vital 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Defical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Defiting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month. Dav. Year) 28/20/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkville MO 21234 State Registrar

W

1108/58

C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jay Jalil Hassani December 29,2011 9:40 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County 800 Southerly Road Unit 1415 Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9, Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 X F Months Days Hours Director 213-36-6025 91 Pahlavi, Iran Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 92a nr 92n t. 2 m. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Maryland | Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 800 Southerly Road Unit 1415 21286-8421 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Yes 2 XNC Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify. White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Century Engineering, Inc. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Civil Engineer 12 06 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Talet Ghafary Mossayeb Hassani permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 W. Pennsylvania Ave. Suite 606 Towson, MD. 21204 Mr. Alexander A. Hassani (Son) Location - City or Town, State (Harford County) 20a. Method of Disposition 20b. Place of Disposition (Name of Tuesday, Jan. 03, 2011 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Signature of Funeral Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr., Cruz 2. Name and Address of Facility Service Licensee /h. Lic.#M00677 Timonium, Maryland 2325 York Road 23a. Part 1. English the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Atheroschrotic Cardiovascular disease Onset and Death Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy been signed by the atte should be detached for Month Day Year Pregnant at time of death
Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perforn death? 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending Natural work iours after death.

neral Director; Aff 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within ? 29b. Signature and title of certifie SCHEN CRNP R154032

State Registrar 800 Southery Rd

Towson, MD 2/286

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Scher CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6:30  $P^{M}$ Alma Harple 2011 December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Manor Care Ruxton Towson Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth (Month, Day, Year) **Funeral** Hours 213-52-8265 96 Director 1 □ M 2 🔀 F Maryland August 3, 1915 Usual Residence of Dece 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes XXNo Maryland Baltimore Nottingham 5 10e. Street and Numbe items 23a or ner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 4530 Wishal Drive 21236 United States of America 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black White etc. 0 þ 1 Never Married 2 Married 1 ☐ Yes 2XX No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify. 27 is marked other than "natural", traumatic event, the Medical Exar White 3XXWidowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ည Harry Henning Marie Hasselbeck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code e 1 and 2 sl of Health a 4530 Wishal Drive, Nottingham MD 21236 Lavern Fortney-Daughter Department of He. 20a. Method of Disposition 20c, Location - City or Town, State Date cemetery, crematory or other place)
Evans Funeral Chapel and 1 Burial XXCremation 3 Removal from State Dec. 30,2011 Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

Evans Funeral Chapel and Cremation Services - Parkville 21. Signature of Funeral Service License 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** rwntially list or notitions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and I-trans that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician by Physician/Medical Division of Vital Records, P.O. Box 68760 the as for use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 month 1 Yes 2X No Day Pregnant at time of death Month Year be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page perform death? Yes 2XX No 1 ☐ Yes 2XXNo Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2**X**] No Other: ၉ this 1 Inpatient 2 I ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1XX Natural work 1 🗌 Yes after death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Funeral Medical 29a. Certifier Kartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and D57722 DECEMBER 30 2011 M.P .

Registrar
DHMH 17 Rev 06-2011

State

EUNARD

QU

RICHARDSON M.P. 1838 GREENE TREE ROAD #800 PILLESVILLE MD 21208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 28<sup>Day</sup> 2011 Physician/ 7:24 PM Yuan-Ju Hsu Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 14024 Welland Terrace Potomac 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number If Under 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛭 F Days March 8, 1914 Months Hours Min. 97 China Director 218-82-5862 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at Director 1 Yes 2 X No Maryland Montgomery N. Potomac 10e. Street and Number 0 10f. Zip Code 10a. Citizen of What Country? Funeral 23a United States 14024 Welland Terrace 20878 ural", or items? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Page 1 and 2 should be filed within 72 hours after of the Health and Mental Hygiene. ant; If item 27 is marked other than "natural", or ☐ Yes 2 🌠 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian 3 ☒ Widowed 4 ☐ Divorced Year or Dates f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ (Not Available) (Not Available) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14024 Welland Terrace, N. Potomac, Maryland 20878 Catharine Liang/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 2012 Department of H Important; If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Germantown, Maryland 4 Donation 5 Other (Specify) All Souls Cemetery . Signature of Funeral Service Licenses <sup>22</sup> Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 a. Runney\_MO1173 willian 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Coronary Heart Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlyin Examine Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Other (specify) Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Dementia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X N 1 Yes 2 No this certificate al or Attending Physician: T s after death. Il Director, After this certifical Division of Vital 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4  $\square$  Nursing Home 5  $\underigne{1mu}{1mu}$  Residence 6  $\square$  Other (Specify) 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred X Natural 5 Pending Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined the Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/29/2011 Oris 00052457

Registrar

DHMH 17 Rev 7/2009

State

parke

9001 Shady Grove Court, Gaithersburg, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Mo-Ping Chow, M.D.

JAN 0 3 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42058 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Z3 3.45 PM EDWARD LAWRENCE HAND DEC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTI MORE WASHINGTON AMNE ARUMDE BURNE map Social Security Numbe If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 07 27 194 1 X M 2 🗆 F Days Hours Min. 69 214 40 7007 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6507 Pampano Dr 21061 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12, Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 \( \text{No } 1964 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed 1970 White Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Maryland State Highway Administration Elementary/Seconday (0-12) 12 College (1-4 or 5+) Electronics Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Edward Lane Hand Dolores Marie Lutz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061 6507 Pampano Dr Glen Burnie, MDTeruko Hand - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Glen Haven Mem Pk 12/28/11 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GJ Gonce Funeral Home 21. Signature of Funeral Service Licensee 169 <u>Pasadena</u>, MD <u>Riviera Drive</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CANCER ME TASTATIC LUNG disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 phy: attending p 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? 1 Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner? Be funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2 No မ 1 Propatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident Investigation after deat Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) filled in 24 hours a Medical 29a. Certifier 🞏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of cortified 29d. Date signed (Month, Day, Year) 29c. License number 005 23 2011 honnie. 336 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 HOSPITAL DR. GLENBURHLE MI) 31. Date filed (Month, Day, Year) State JAN 0 3 2012 Registrar

DHMH 17 Rev 7/2009

Amend 20b per Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year MYRTLE JOHNSON 12 2011 Э. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PIKESULL BALTIMORE PIKESULLE FUNDA OF WD Age (In yrs. last birthday)
Yrs. If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Months Min 1 ■ M 2 ■ 213-26-7288 Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumains event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No **Funeral Director** fimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ordel 21215 ISA tvenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Be Completed by lack 3 ₩idowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use letiled) dary (0-12) College (1-4or 5+) a 17. Father's Name (First, Middle ည 19a. Informant's Name/Relationship (Type. Print) (Daughter) 19b. Mailing Addrass (Street an Number or Rural Route Number, State, Zip Code) 110 krnestine 20a. Method of Disposition 20b. Place of Disposition (Name of Cemetery, crematory 1 Burial 2 □ Cremation 3 □ Removal from State 1/9/2012 4 ☐ Donation 5 ☐ Other (Specify) tores. 21. Signature of Funeral ervice Licensee 23a. Part1. Enter the dise shock, or head failur e, or complications List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Foal disease or condition resulting in death) Physician MAGIA /Medical as a consequence of) Examiner SUSMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ After this certificate has been si funeral director, page 2 should 1 ☐ Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No 1 🔲 Inpatient Other: 4 Nursing Home 5 Residence 6 □Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No the 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) was \$ \$ \text{Nach} of add-manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6000000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. SiAMM #208 BONGTHONS, MP14/DAB 20209 2835 Smilh Demue 2012 32. Registrar's Signature 31. Date filed (Month. State 3 Registrar parke

DHMH 17 Rev 1/2001

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Maryland / De	partment of I	Health and	Mental Hy	giene	
		State Registrar	C	ertificate of l	Death		Reg. No. 20	1 42060
Physicia	ın/	1. Decedent's Name (First, Middle, Last)  Raphael D. Tones				2. Date of De Month	Day Year	3. Time of Death
Medic	al	Raphael D. Jones  4a. Facility Name (if not institution, give street and numb	porl	4h Cit. Tawa	or Location of Dea	Decer	4c. County of Dea	
Examin	er	University of Maryland	Medical Cent	er Baltir	nore			
Funeral Director		5. Social Security Number 6. Sex 1 X M 2 🗆 F	7. Age (In yrs. last birthday 79	/) If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th 9. Bit y, Year) Co	rthplace (State or Foreign ountry)
		Usual Residence of Decedent	110.			09 00	5 1932	Jamaica
yland -f sho ed at	ctor	10a. State 10b. County	10c. City, Town or					10d. Inside City Limits  Yes 2 □ No
r 28a notifi	Director	MD NA  10e. Street and Number	Balt.	imore			10g. Citizen of What C	
with the 23a cast be	eral	1511 East 33rd Street			21218		U.S.	-
leath items er mu	Funeral		ent Ever in U.S. 13	3. Was Decedent of H If Yes, specify Cuba	Hispanic Origin? (	Specify Yes or No-	14. Race - Ame	
36 after o	l by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, Give	2 <b>X</b> No	1 Yes 2 X No		rico i licali, cto.)	Black, White Specify: <b>B1</b>	
nours natura ical E	Completed	15. Decedent's Education		cedent's Usual Occup	oation		16b. Kind of Business	
215 in 72 h e. nan "n	dwc	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4	(Giv	ve kind of work done DO NOT use retired)	during most of w	orking		
d with ygien ygien her th	Be Co	12th grade na		Carpente	T		Construc	tion
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland thand Mental hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	To B	17. Father's Name ( <i>First, Middl</i> e, <i>Last)</i> Ate Jones				ame (First, Middle, h Eliza)	Maiden Surname) beth Gayl	e
Aarylanc should be file n and Mental F is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street			r, City or Town, State, Zi	
e, Mand 2 sl and 2 sl Health 8 tem 27 i		Norman Jones-son	674	Autumn	Ave, B	rooklyn	NY 1120	8
Baltimore,  cernit. Page 1 and Department of Heal Important: If item: any injury or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from S		position (Name of rematory or other plac	ce)	Date	20c. Location - City of	r Town, State
it. Pag rtmen rtant: njury		4 Donation 5 Other (Specify)	Drui	d R <b>i</b> dge		7/2012	Pikesvil	le, Md
Baltimore, N permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr		21. Signitur of Funeral Service Licensee	]	March F/ 4300 Wab	`H°₩est ash Av	e, Balt	imore, Md	21215
FT I		23a. Par 1. Enter the disease, or complications that ca shock, or heart allure. List only one cause on eac	used the death. Do not e	nter the mode of dyir	ng, such as cardia	ac or respiratory an	rest,	Approximate Interval Between
- Physi i n	ı,	Immediate Cause (Final disease or condition	te Myeloic	Leuken	ria			Onset and Death
Medical Examiner		resulting in death)  Due to (o	r as a consequence of):					
	ner		r as a consequence on.					
ansit and	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
ian an	E	resulting in death) Last Due to (o	r as a consequence of):					
ate be	dical	d						
oo/ ertifica ding ph	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	ome of pregnancy				22d Date of de	Mirrory
<b>BOX</b> death c the attented for u	iciar	in the past 12 months?  1 Ves 2 No 4 Pregnance	irth 2 Fetal death 3 ant at time of death 5	☐ Ectopic pregnand ☐ Other (specify)	cy		23d. Date of de Month	Day Year
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s that the	by	Part II. Other significant conditions contributing to dea	ath but not resulting in the	e underlying cause gi	ven in Part I.		obacco use contribute to	
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VITAI MECOITAS, ysician: The law requires is certificate has been sig director, page 2 should t	Completed					24a. Was autop		utopsy findings available completion of cause of
n: The		25. Was case referred to medical		26 D	lace of Death (Ch	1 🗆 Yes		s 2 🗆 No
VITA ysicia s cert direct	To Be	examiner?	patient 2 ER/Outpat	Oth	er.		dence 6 Other (Spe	cifu)
OF Physical Internal		27. Manner of Death 28a. Date of	<del></del>	of 28c. Injur	y at		ow injury occurred	
tendi death. Jeath. tor: Ai	Certificate:	2 Accident Investigation		M 1 🗆	Yes 2 No			
LIVISION al or Attendir s after death. I Director: Af ed in by the fu		4 Demiside determined 28e. Place c	of Injury - At home, farm, s g, etc. (Specify)	street, factory, office		28f. Location (S City or Tow	Street and Number or Ru n, State)	ıral Route Number,
Dspita hours uneral ly filler	Medical	29a. Certifier 1 Certifying Physician: To the be-	st of my knowledge, deat	h occurred at the time	e, date and place	e, and due to the ca	ause(s) and manner as s	tated.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Mec	(Check 2 Medical Examiner: On the basis only one) 3 Certifying Nurse Practitioner:		ge, death occurred at	the time, date and	place, and due to t	he cause(s) and manner	as stated.
To vitin		29b. Signature and title of certifier	115	29c. Licens			29d. Date signed (Mont	
		Referra Baach  30. Name and address of person who completed cause			63743	31	lecember a	21, 2011
H			2 South G		reet 3	altimore	, MD 212	104
Stat	_	31. Date filed (Month, Day, Year) 32. Reg	gistrar's Signature		00.10		1 1	•
Registra	ir	JAN 0 3 2012 January	1. Sal	2				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42061 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 10:05 A.M AROBS 2011 D Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 6840 DUNDALK 41 . Social Security Number 7. Age (In yrs. last birthday) If Under 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex **Funeral** (Month, Day, Year) Days Hours 218-03-517 **Director** 1 X M 2 🗆 F or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No UND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 212 22 items 23a U-SA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Was Decedent Ever in U.S.

Armed Forces?

1 ☑ Yes 2 ☐ No

If Yes, Give

Year or Dates. 

MATINUS Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Merchanth INCER permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be , 's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 9 Es Au ACOBS ACOB 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nephew 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, or o shock, or heart failure. List or Approximate Interval Between Onset and Death Immediate Cause (Final Disen iounsculm Physician/ ARtenoscieno disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) death certificate be executed and I-tran. that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal Gea 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? Month Day Year 1 Yes 2 g Unknown 2 No the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performed 2 🗌 No Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. Natural 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21224 280 1/18ms . Registrar's State

Registrar

11-09805 Claire Kispert Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2011 42062

	R	For State	Certific	ate of	Death			Reg.	No.		
Physician Medical Examine	1								year 19, 2011	3	3. Time of Death 1510 hrs
7	4	<ul> <li>Facility Name (if not institution, give str 9307 Carney Road</li> </ul>	eet and number)	4	b. City, Town, o Parkville	r Location of			4c. County of Baltimore	Coun	•
Funeral Director		5. Social Security Number 214-13-0039 6. Sex 1 Months Days Hours Min. 1 Mov. 10 Months Days Hours Min. 1 Mov. 10 Mov. 10 19									
nd show any	1	Sual Residence of Decedent	10c. City, Town		ville						1Cd. Inside City Limits 1 Yes 2 No
ith the Maryland  23a or 28a-f show notified at once.	Ulrector	0e. Street and Number 9307 Carney Ro	oad		10f. Zip Code 2	1234		10g	Citizen of Wha	at Count	ry?
r death w	<b></b>	1 Never Married 2 Married 1 3 Widowed 4 Divorced If Y	Dates:	If Ye	s Decedent of Hes, specify Cuba	o s <i>pecify:</i>	Puerto Rica	n, etc.)	White, Specify:	etc. Wh	ite
5-0036 led within 72 hours after the water all	Completed	15. Decedent's Education (Specify only F Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	t's Usual Occup ost of working lif culum	specia	se retired) alist	t l			onsAcadem
다 글 뜻 <u>후</u> 됐 다	Be Co	7. Father's Name (First, Middle, Last) John Arro				Anı	ne G	olding			
MD 21 12 should 1 th and Men n 27 is man	2	9a. Informant's Name/Relationship (Type Jason Kispert	/husband	930	7 Carn	ey Ro	ad Ba	altimo	er, City or Town	21	234
s 1 and free free free free free free free fre		0a. Method of Disposition  1 X Burial 2 Cremation 3 4 Other Specify:		tory or oth edHe	eartof	Jesu		4/12	Balti	mor	e MD
Baltimo permit. Page Department of Important:	Ī	21. Skin fure of Funeral Service License 22. Name and Address of Facility 300 Mace Ave. Barrier Connelly Funeral Home of Est								sse	x 21221
Physician Wordical Examiner	1		<sup>ine.</sup> ypertensive Car					piratory arres	t, shock, or hea	п	Approximate Interval Between Onset and Death
		Sequentially list conditions, b	e to (or as a consequence of):								
	틹	Disease or injury that initiated C.	e to (or as a consequence of):				_	_	-		
execul	Medical	d d A	MENDED 23a, pt.II,	27, pe	er me,g	924 2-2	22-12	sm			
Sox 68 leath certificath certi	Physician/Me	3b. Was decedent pregnant in the past 12 months?	The second of the settle	2 Fe	tal death 3	Ectopic	pregnancy		23d. Date of o	delivery Da	ay Year
<b></b>		Part II. Other significant conditions co Behcet's Disease	ntributing to death but not resulting	ng in the u	inderlying cause	given in Part	t I.				he cause of death? ably 4 Unknown
Division of Vital Records, P.C to the Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed to completely filled in by the funeral director, page 2 should be detained.	Completed by						_	24a Was ar autopsy perform 1 Yes 2	/ pi		opsy findings available ompletion of cause of S
ital Rec	B B B	25. Was case referred to medical examiner?			26.Pla	ce of Death (C					
Vita	인	1 Yes 2 No		Outpatient		-			esidence 6		Scene
ision of Attending Phyride action: After the funeral by the funeral		27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	(Month, Day,Year)	Time of I	1	jury at Work? Yes 2 1	No		ow injury occurre		Deute Number City
Divis	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, (Specify)					or Town, Sta	ate)		al Route Number, City
To the Hos within 24 hr To the Fun completely	edical	one) 2 ✓ Medical Examiner:One	To the best of my knowledge, do n the basis of examination and/or nd manner stated.	eath occur investigat	tion, in my opini	on, death occ	ce, and due urred at the	to the cause e time, date a	(s) and manner nd place, and di 29d. Date signe	ue to the	e cause(s)
(S) M	2	29b Signature and title of certifier	Week 3080			nse number			December:		
Orte	_	30. Name and address of person who con Victor Weedn MD JD Assi	stant Medical Examiner		/. Baltimore	Street, Ba	ıltimore,	MD 21223	3		
Sta Registr	-	31. Date filed (Month, Day, Year)  AND 3 2012	2. Registrar's Signature	par	d						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <sup>Day</sup>23, 2011 December 12:20 A M Mary Ann Kuykendall Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Burtonsville Sanctuary at Holy Cross Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, Days Hours Min **Director** 220-28-5886 79 1 □ M 2**X** F Usual Residence of Decedent Jan 23, 1932 Maryland 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Howard Fulton be filed within (2 more). ental Hygiene.
Inked other than "natural", or items 23a or 28.
Ite event, the Medical Examiner must be no 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12049 Scaggsville Road 20759 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 21.4 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: 3 XXWidowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Bookkeeper Clerical Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) 2 Crispin Ricketts Annie Dora Viehmyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda J. Cirri / Daughter 5828 Oklahoma Road, Eldersburg, MD Baltimore, 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 12/27/2011 Burtonwville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. GK M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph sician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of a Exami Hospital or Attending Physician: The law requires that the death certificate be executed trar Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Month Year Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ HIO CVA Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perforn death? AD certificate 1 🗌 Yes 2 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 No Other: 1 Yes မ 1 \_ Inpatient 2 \_ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of : After t Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No 1 Natural 5 Pending injury s after death.

I Director: Af
od in by the fu Accident Suicide Investigation 6 Could not be n. .in 24 hour. .e Funeral Dir. .v filled in bv 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical within 24 hou

To the Fune

completely fi 29a. Certifier 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Datę signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

JAN 0 3 2012

10 V

32. Registr

2180-2-2613

11-09816 Jessie Steven Knopp

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1888 of Waryland Department of Health and Mental Hygiene

2011 42064

		- For State	, or maryland, a	Certifi	cate of De	eath		Re	 eg. No	
Physicia		Decedent's Name (First, Middle,La	ist)				143	Date of Deal     Month	Day Year	3. Time of Death 0802 hrs
ledical Exami		JESSIE.	S. KNODI	)				December		
		4a. Facility Name (if not institution, g	ve street and number) /				r Location of De	ath	4c. County of Dea	יטור :
		1306 Morling Avenue	1			altimore	ar If Under 24	Um I P Data of Bir	th (MM/DD/YYYY) 9. B	Rirthplace (State or
Funeral Director			1	n yrs. last b	N	Under 1 Year Ionths Day		Min.	Fore	eign Country)
Director		CLIVI WOUNT	YM 2 F	25	Yrs.			11/10	11986	pourity) P/L/
any .	-	Usual Residence of Decedent  10a, State 10b, County	I10	c. City. Tow	vn or Location					10d. Inside City Limits
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Maryland 28a-f show d at once.	흱	10e, Street and Number		0	a/hm	f. Zip Code	<u></u>		0g. Citizen of What Co	ountry?
e Mar	Director	120/	200			21	2 11		U. 3A	
death with the Maryland or items 23a or 28a-f sho must be notified at once.		11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was De	cedent of Hi	ispanic Origin?	( Specify Yes or No	- 14. Race - Am	erican Indian, Black,
ath w	Funeral	1 Never Married 2 Marrie	Armed Forces?		If Yes, s	specify Cuba	n, Mexican, Pue	erto Rican, etc.)	White, etc.	. ,
re de		3 Widowed 4 Divorce	ed If Yes, Give Year	1 140	1 Yes	2 N	specify:		Specify: 4	Shife
urs af	d b	15. Decedent's Education (Specify	or Dates: only highest grade comple	eted) 16	a. Decedent's U		ation (Give kind e. DO NOT use		16b. Kind of Busines	s/Industry
72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)				B. DO 1401 436	retirod/	11.00	20
5-003( ed within Tygiene. other tha	E	12			H	VAC		(=: . A A' . 1 N -	HVA	10
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica		17. Father's Name (First, Middle, La	1	7				ame (First, Middle,	maiden Surname)	
2121! hould be fil and Mental F is marked utic event, 1	o Be	19a. Informant's Name/Relationship	(Time Print	IR	10h Mailing Ad	drass (Stra	Z Z		nher City.or.Town. Sta	ate, Zip Code)
D 2 shoul and M	ř	Izel Starr Knop		Ĩ.	2214 C	raley	RD. Wi	ndsor,PA	nber City or Town, Sta	mazinal
<b>∑</b> 2 d d d d d d d d d d d d d d d d d d	ŀ	20a. Method of Disposition	JIJ rer	20b. Plac	e of Disposition	(Name of co	emetery,	Date Date	20c. Location - City	or Town, State
Baltimore, permit. Pages I an Department of Her Important: If ite		1 Burial 2 Cremation	Removal from State	crem	natory or other	olace)		12/200	mall x	and mid
timen trant	H	4 Donation 5 Other Speci 21. Signature of Funeral Service Lic	fy:	Jay	22 Name	and Addres	ss Facility	Propola	- ASKTON	ENLIP COL
Balti permit. Departir Imports	-	21. Signature of Funesal Service Ele			How	10 DA	3134	Willaw	Showard	81303
Physician	$\dashv$	23a. Part I. Enter the disease, or con	nplications that caused th	e death. Do	not enter the m	node of dying	, such as cardia	ac or respiratory ar	est, shock, or heart	Approximate Interval Between Onset and
/Medical		failure. List only one cause on Immediate Cause (Final disease	each line.D11ated a. Oxycodone		.10 <b>my</b> opa	thy co	отриса	ced by ar	conol and	Death
£xaminer		or condition resulting in death)	Due to (or as a consequ							
		Sequentially list conditions,	b	-20 Sall 1982						
	亨	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseq	ueride of):						-
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60, ate be executed ohysician and ne burial - transi	Medical	■ UNPENDED	AMENDED 23a,	2/,pe	r me,g9	24 2-	15-12 SI	n		
760, icate be physic the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregnan		3	Estania pre	anancy	23d. Date of deliv	very Day Year
Sox 687 death certific e attending p for use as th	ä	past 12 months?	1 Live birth Pregnant at tir	me of death	2 Fetal of	(Specify)	Ectopic pre	egriancy	l Working	buy , ou.
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unkno	wn 9 Unknown		o Other	(Opcoy)				
that the d		Part ii. Other significant condition	s contributing to death b	out not resu	iting in the unde	erlying cause	given in Part I.			to the cause of death?
P.O. res that the signed by be detacled	Completed by							_		Probably 4 Unknown
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9CO te law te has ge 2 s						_		perfe 1 ✓ Yes	ormed? death 2 No 1	1? Yes 2 No
E The Triffica or, pa		25. Was case referred to medical				26.Pla	ce of Death (Ch	eck only one)		
Vital Rec yrician: The his certificate director, page	o Be	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 EF	₹/Outpatient 3	DOA	Other <sub>4</sub> N	ursing Home 5	Residence 6 🗸 0	ther: Scene
Of Negative of Physics of the Physic	7: To	27. Manner of Death	28a. Date of Injury (Month, Day,Yea		3b. Time of Injur	y 28c. In	jury at Work?	28d. Describe	how injury occurred	
On tendir or: A the fu	ţ	1 Natural 5 Pending 2 Accident Investig				1	Yes 2 No			
Division of Vital Records, ral or Attending Physician: The law requir is after death.  al Director: After this certificate has been is led in by the funeral director, page 2 should!	ij	3 Suicide 6 Could r	28e Place of Inju	ry - At home	e, farm, street, f	actory, office	building, etc.	28f. Location or Town,		Rural Route Number, City
Division of N To the Hospital or Attending Ph. within 24 hours after death. To the Funeral Director: After ti completely filled in by the funeral	Certification:	4 Homicide determine	(0000)							
e Hos 124 h e Fun		(01.001.011)	sician: To the best of my ner:On the basis of exami	knowledge,	death occurred	at the time,	date and place,	and due to the cau	use(s) and manner as s e and place, and due to	stated. o the cause(s)
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the	Medical	1	and manner stated.	n /acron and/	o. mreatigation		nse number		29d. Date signed (	
	2	29b Signature and title of certifier					C.M.E.		December 31,	
		() Continue					Z.171. L.			
		30. Name and address of person was Laron Locke MD. Ass	no completed cause of delistant Medical Exar	ath (Item 23 miner C	3a) 300 W. Balti	more Stre	eet. Baltimo	e, MD 21223		
			32. Registrar's							
S	tate	31. Date filed (Month, Day, Year)	A Joz. Negistral		a del					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42065 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month 14 charles Keyser T. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NA 5. Social Security Number more Maryland 6. Sex If Under 1 Year \_ If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours Min 220 42 6291 1 X M 2 🗆 F **Director** 66 MARYLAND Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No SYFESVILLE mo CARROLL 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 4638 BARTHOLOW ROAD 21784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black. White, etc. 1 Never Married 2 Married ō þ ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. If Yes, Give Year or Dates Specify: WHITE 3 Widowed 4 Divorced natural" Completed the Medical Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) STRUCTURES MANAGER ノユ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES M. KEYSER ZIMMERMAN 00215 I and 2 should be Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. OANN KEYSER 4638 BARTHULOW ROAD SYFESVILLE MO 21784 Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 12/31/2011 SOUTH CANNOLL CREM WINFIELD, MO 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J N Zum Brun Fit & MON Co 6028 SYKESVILLE AN ELDERSBURG MO 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ Subdural disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner For Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CE TOTATION APPROVED BY MEDICAL EXAMINER Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran-Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Dav Year Month Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed myocardial peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed this certificate 25. Was case referred to medical disease 1 ☐ Yes 2 26. Place of Death (Check only one) Be examiner?
1 Yes Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 2 No 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 🗌 Pending work? 1 ☐ Yes 2 🗙 No 0100 AM Investigation Fall while getting out of bad December 29,2011 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled center Jarroll Hospital 200 AUR. WESTMINSTER Memorial Medical Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MD 2/1/57 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Curtifying Nurse Practitioner: To the best of my months up, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Curtifying Nurse Practitioner: To the best of my months up, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10048 29,2011 December 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balkmore MD 2120 E. Dw 22 South 31. Date filed (Month, Day, Year)

JAN 0 3 2012 32. Registr y s Sign a Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03 40 AM 2011 George Martin King, Sr. December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Morningside House Parkville If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Days 1 XM 2 □ F Hours 76 Director 1935 218-32-7356 10. Baltimore, Maryland Usual Residence of Decedent Fshow 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8716 Eddington Road 21234 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 X Married Yes 2 No Yes, Give Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Superintendent Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) မ George Edward King Grace Elizabeth Walter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8716 Eddington Road Parkville, Maryland 21234 Mary King (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Evans Funeral Chapel-Bel 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 28,2011 Forest Hill, Maryland Air Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Read Parkville, Maryland 21234 -condrae 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ZOL 0 Ci Sequentially list conditions Examiner cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) 2011 Completed by Physician/Medical 9 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy perform ☐ Yes 2 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, Hospital: Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 / Natural 5 Pending death. Accident Investigation within 24 hours after deatl 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 0 3 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dee. Wa

32. Registrar's Signature

100

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

12/27

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>2</sup> 2011 December 27 7:55  $P^{M}$ Rita M. Kozla Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 011-01-8133 Director 1 🗆 M 2 🗶 F 96 Sept. 1, 1915 Massachusetts Usual Residence of Deceder 28a-f shov 10d. Inside City Limits 10c. City, Town or Location at 10a. State 10b. County Director must be notified 1 Yes 2 X No Maryland Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code o items 23a United States 20814 4400 Highland Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. or i ð 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify ייסייי ביו וs marked other than "natural", other traumatic event, the Medical Exar Specify: White 3 X Widowed 4 Divorced WWII Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 I h and Mental Hygiene. **7 is marked other than "**n United States College (1-4 or 5+) Elementary/Secondary (0-12) Marine Corps Employee Relations Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Helen Fitzgerald Edward Callahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important; If item 27 is any injury or any 8301 Wind Fall Road, Springfield, Virginia Elaine Kozla/Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 1  $\boxtimes$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia Arlington National Cem. unk. Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signature of Funeral Service License Mullion 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a conse Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence o resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? performed? Yes 2 No I or Attending Physician: after death.
Director: After this certifica 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ဂ္ဂ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 5 Pending work?
1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital within 24 hours a To the Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 12(28/11 00051514 of person who completed cause of death (Item 23a) (Type, Print) 10301 Georgia Ave +203 Silver Spring, mD 20902 Ahmed Hishmat MD 31. Date filed (Month, Day, Year) State 3 2012 JAN 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

1955

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER Physician/ Suzette Marie Kaufmann Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TOWSON BALTIMORE SAINT JOSEPH MEDICAL CENTER 6. Sex 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Hours 216-48-4640 **Director** 1 🗆 M 2 🔀 F 64 Nov 3. Maryland ( Usual Residence of Decede 28a-f show 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location Director is 23a or zou. must be notified a' 1 🗌 Yes 2 😾 No MD Baltimore Reisterstown 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral with must 17 Jacob Lee Court 21136 U.S.A. items ? hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Examiner Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 0 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Widowed 4 Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working within 72 h and Mental Hygiene.

is marked other than life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Veterans Admin. Counselor 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Helen Figler Harry W. Morton, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 17 Jacob Lee Court Reisterstown, MD Lee J. Kaufmann Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/31/11 Pikesville, Maryland 4 Donation 5 Other (Specify) Druid Ridge 11824 Reisterstown Road 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21136 Reisterstown, MD ELINE FUNERAL HOME 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MALIGNANT PLEURAL EFFUSION Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury NEUROENDOCRINE LUNG CANCER requires that the death certificate be executed CELL burial-trar that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Box 68760 the phys IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ned by the atten edetached for u in the past 12 months? Year Month Dav Pregnant at time of death 2 X No 1 ☐ Yes 2 ☑ 9 ☐ Unknown 9 | Unknown Division of Vital Records, P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ METASTASES 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Jas page 2 performed?

1 Yes 2 No certificate Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes \_ 2 🔀 No ျှ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: **Hospital or Attending** 1X Natural 5 Pending 1 Yes 2 🗌 No death. neral Director: A filled in by the fi Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hin 24 hours a the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the I

comple only one 29d. Date signed (Month, Day, Year, completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND M.D LOW IMOTH 4

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year,

3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #3&26 Per Phy G923 1/03/2011 JH
State of Maryland / Department of Health and Mental Hygiene amend #19a Perril G923 1/05/2011 JH State of Maryland amend #19a PerFH State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Do Ruth M. Lee 24 Pay Physician/ 12nth 201°1 Medical a. Facility Name (if not institution, give street and number)
Balt./Wash. Medical Center 4c. County of Death 4b.\_City, Town, or Location of Death Examiner Glen Burnie Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign cial Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 219-16-6585 9/21/22 NC Months Days Hours Min 1 M 2 F 89 Yrs. **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hyglene.

Importment: If item 27 is marked other than "natural", or items 23a or 28a-f show amy projury or other traumatic event, the Medical Evanium. 10c. City, Town or Location Pasedena 10d. Inside City Limits 10b, Count **Funeral Director** Baltimore 1 🗌 Yes 2 🔀 No 10f. Zip Code 21122 Street and Number 10g. Citizen of What Country? 7951 Lee Hall Rd USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? African 1 X Never Married 2 Married þ 1 ☐ Yes 🏞 No Specify: If Yes, Give Year or Dates SpecifyAmer. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Private Duty Elementary/Seconday (0-12) College (1-4 or 5+) Domestic 9 Be 17. Father's Name (First, Middle, Last)
Alvah Odell Lee 18. Mother's Name (First, Middle, Maiden Surname)
Iclon Baker 2 19a. Naomi NB ehechsisterint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7951 Lee Hall Rd,Pasedena,MD 21122 Nammi Lee?Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
MD Nat L Mem PK 1 Burial 2 Cremation 3 Removal from State Laurel, MD 12/30/11 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hari P. Close FSvs, PA 5126 Belair Rd, Balt., MD 21206-5105 Signature of Funeral Service Licens 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ redial disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? jo Month Day 5 Other (specify) Pregnant at time of death signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform 24 hours after death.

Funeral Director, After this certificate 2 🗌 No 1 🗌 Yes 1 ☐ Yes 2 🕏 25. Was case referred to edical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No ၉ 1 🗌 Yes 1 Inpatient XX ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred iniury Natural 5 Pending Accident Investigation completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 29c. License number Name and address of person who completed cause of death (item Date filed (Month, Day, 32. Registrar's Signature State JAN 0 3 2012

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 5 per fh 9923 1-6-12 vt State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ :54 0 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1108 Marley Creek Drive Anne Arundel Glen Burnie If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year)
January 5, 9. Birthplace (State or Foreign Country) Maryland Social Security Number 219–40–9571 If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 5 F Months 69 1942 Director Usual Residence of Decedent or 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗆 Yes 2 🛣No Glen Burnie Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21061 United States 1108 Marley Creek Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ş 1  $\square$  Never Married 2  $\square$  Married ☐ Yes 2 X No 1 ☐ Yes 2 XNo Specify: Yes, Give Specify White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Dental Office Office Manager 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Emma Virginia Ittner Lewis Reinholt Thalberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1630 Witt Drive Glen Burnie, MD 21060 Rhonda Witt Sister 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 Deurial 2 Cremation 3 Removal from State Jan 02 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 2012 Glen Haven Cemetery Signature of Funeral Service incensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road Pasadena Maryland 21122201 23a. Part/J Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ rcinoma disease or condition resulting in death) Medical as a consequence of) Examiner run Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or finjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death been signed by the a should be detached 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 sl autopsy performed' is certificate his director, page 1 🗆 Yes 2 🗆 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: ပ္ 1 🗀 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending Accident 1 🗌 Yes 2 🗌 No after death Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined To use within 24 hours are To the Funeral Directory Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30 and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name

Registrar

State

Date filed (Month, Day, Year)

3 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month <sup>Day</sup> 28 2011 9:15 Marie Anne Lusby  $P^{\mathsf{M}}$ December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carrol1 Homestead Assisted Living Sykesville 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min **Director** 134-40-6185 1 🗆 M 2 💢 F 94 Maryland Jan. 8, 1917 Usual Residence of Deced 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location notified at Director 1 Yes 2 No Maryland Carrol1 Finksburg 10 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a o Medical Examiner must be Funeral United States 2201 Cedar Hill Drive 21048 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other any injury or other train. Black, White, etc. ρ 1 Never Married 2 Married Yes 2 XNo If Yes, Give Year or Dates 3 Widowed 4 □ Divorced 1 Yes 2 No Specify Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Pound Bertha Costello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Lusby / Son 2201 Cedar Hill Dr., Finksburg, Maryland 21048 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 12/30/2011 Baltimore, Maryland Metro Crematory Inc. 22. Name and Address of Facility Cremation Society of Maryland Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Physician/ disease or condition corgran Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or injury that initiated events resulting in death) Last burial-trans Due to (or as a consequence of) nding physician Physician/Medical The law requires that the death certificate be Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li Fetal usa
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year signed by the at Id be detached for P.O. Part II. **Other significant conditions** contributing to dea<sup>t</sup>h but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed Yes 2 has page 2 Hospital or Attending Physician; The
 24 hours after death.
 Funeral Director: After this certificate I Division of Vital filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\overline{\chi}\) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Ernesto Mendoza, M.D.,

31. Date filed (Month, Dav. Year,

826 Washington Rd., Ste. 120, Westminster, Maryland 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ DECEMBEZ 31 2011 John Melvin Lort Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Deat THHE BAGIMORE WASHINGTON MEDICAL MER 1 8. Date of Birth 9. Birthplace (State or Foreign If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) If Under 1 Year Days Min 216-16-2888 88 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland must be notified at Director 1 Yes 2x No MD Anne Arundel Pasadena 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 7626 Paradise Beach Road 21122 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 11. Marital Status 14. Race - American Indian Black, White, etc. 2 1 X Never Married 2 ☐ Married (JOH-H) (Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify. Completed 3 Widowed 4 Divorced Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Management Banking injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ۵ William Gertrude Wood Lort 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Margaret Krantz / sister Glen Burnie, Maryland 21061 Page 1 and 2 12 5th Avenue, N 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 01/04/2012 Glen Burnie, Maryland 4 Donation 5 Other (Specify) Atlantic Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD M01357 Singleton Funeral & Cremation Services, P.A. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. 23a. Part 1. Onset and Death Immediate Cause (Final Physician/ 144 disease or condition resulting in death) 10 Medical **Examiner** TIBRIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Other (specify) signed by the a Id be detached f 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 🗹 Unknown 1 Yes 2 No 3 Probably been signature should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No certificate 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗷 No Hospital: Other: မ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this . Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 \square Yes Certificate: 28d. Describe how injury occurred After Natural injury 5 Pending 2 🗌 No Accident Investigation after death Director: / d in by the f 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, To the Hospital or within 24 hours aft To the Funeral Discompleted filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Name and address of person who comple cause of death (Item 23a) (Type, Print) Glen Burnie MD 20161 State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001

State

Registrar

Zabiullah Ali, M.D.

31. Date filed (Month, Day Year

32. Re

istrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:23 PM **GEORGE** RODERICK LOUDEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Baltimore City Baltimore Hospita 8. Date of Birth (Month, Day, Year) 03/23/1923 Social Security Namber If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday 1 X M 2 □ F Hours Min Country **Director** 182-18-8930 Pennsylvania ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 X No MD Anne Arundel Co. Brooklyn Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 United States 801 Sunnyfield Lane "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 

Yes 2 

No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Philadelphia Elementary/Seconday (0-12) College (1-4 or 5+) Gas Works 10 Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Edith Powe11 Joseph Louden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Baltimore, MD 801 Sunnyfield Lane Mrs. Linda J. Swenson/daughter 20a. Method of Disposition
1 

Marial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) St. Peter & Paul Cem. 01/05/2012 Broomall, PA 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Serv Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Septic Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to inmediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physicial Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown (1) s been signed by should be detail 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ş 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed ouder 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page 2 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Natural 5 Pending iniurv 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a, Certifier 1 Secritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed within 2 To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  $M_{i}$ P. 24064 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Battomae, MD 00 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #11 Fer FH 6923 1/03/2012 The State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 29, DECEMBER 2011 2:49 P M **EVELYN** M Medical 4a. Facility Name (if not institution, give street and number) 4c, County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE BALTIMORE ONE POMONA WEST, #12 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. . Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** Months 1 □ M 2 🗶 F 1/27/137/19/19 92 MD214-18-7327 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland items 23a or 28a-f sho per must be notified at Director 1 Yes 2x No MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral 21208 USA ONE POMONA WEST, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, "natural", or ite Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc ☐ Never Married 2 M Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Widowed 4 Divorced Specify: WHITE Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) 2 MARKS SHEMER **JENNY** ABRAHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau BRIDLE COURT, REISTERSTOWN, MD MARLY GOLOSKOV/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
ANSHE EMUNAH AITZ
CHAIM CEMETERY 1X Burial 2 Cremation 3 Removal from State 01/02/2012 4 Donation 5 Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licenses Name and Address of Facility SOL LEVINSON & BROS., INC. 21208 PIKESVILLE, MD 8900 REISTERSTOWN ROAD, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final THEROSCLEROTIC EREBRO VACCILL Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: been signed by the attendir should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy has 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 욘 this 24 hours after death.
Funeral Director: After thi leted filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2.

To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 385 G1 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 235 32. Registrar's Signature State

Registrar

11-09776 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Geraldine Ruth McMichael State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day December 28, 2011 Medical Examiner 2100 hrs eRA 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 6811 Eastbrook Avenue Baltimore 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State o **Funeral** county Sylvan, 4 Min Director 18 -88 1 M 2 F Usual Residence of Deceder 10d. Inside City Limits iny 10a. State 10b. County 10c, City, Town or Location Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. MIMORE 1 Yes 2 No Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? White etc. 1 Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 W No Yes \_\_\_, ies Yes, Give Year Dates: 4 Divorced 1 Yes 2 No specify: Specify: Ď 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 iHORE SOVELLIA 165 17, Father's Name (First, Middle, Last) LAKNOWN Be 19a, Informant's Name/Relationship (Type, Print) ၉ (Street and Number or Rural Route Number, City or Town, State Zip Code) 20b. Place of Disposition (Name of cemetery crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify 22. Name and Address of Facility W. OABROUSK, / HOME **Physician** 234. Part/l. Enter the disease, or complica ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear veen Onset and failure. List only one cause on each /Madical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Ėxaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine eques. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial - trans Physician/Medical UNPENDED AMENDED Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day detached for use as Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 V No 9 Unknown Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ģ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed certificate has been director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed ✓ Yes 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other<sub>4</sub> Nursing Home 5 Residence 6 🗸 Other: Scene After this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 5 Pending 1 Yes 2 No the Funeral Director: hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

OCMF 2006

State

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD

31. Date filed (Month, Day, Year)

O.C.M.E.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

December 29, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	Department of Healt		tal Hygiene	9	the state of the s
		_	State Registrar	Certificate of Deat		Reg. No	<u>. 2011</u>	42074
ı	Physicia Medic		1. Decedent's Name (First, Middle, Last) Wanda Lee Mitchell			ate of Death lonth ec. 3	0 20 1 1	3. Time of Death 2:30 p M
بالأصار	Examin	_	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Locat			c. County of Death	
set.			4 Hammock Trail  5. Social Security Number   6. Sex   7. Age (In yrs. last bi		lle Rive	ate of Birth	Balti	
	Funeral Director		218-82-3969 Usual Residence of Decedent	Months Days Hou		nonth, Day, Year)	960	nplace (State or Foreign ntry) MD
	a-f show fied at	Director	10a. State 10b. County 10c. City, Tov	wn or Location Middle River				10d. Inside City Limits 1 ☐ Yes 2 ☐XNo
	or 28		10e. Street and Number	10f. Zip Code		10g. C	Citizen of What Cou	ıntry?
	with with s 23a ust b	Funeral	4 Hammock Trail	212	220	1	USA	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Morried  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic If Yes, specify Cuban, Me:  1 ☐ Yes 2 ☒ No Spe	xican, Puerto Rican	es or No- , etc.)	14. Race - Ameri Black, White Specify:	
5-0	2 hour "natu	plet	15. Decedent's Education (Specify only highest grade completed)	ia. Decedent's Usual Occupation (Give kind of work done during	most of working	16b.	Kind of Business/li	ndustry
121	thin 7: ene. than than	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ife. DO NOT use retired) Accounts Rec	eivable		Taylor	Tech.
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/lan	d be fi Mental arked atic ev	유	Robert S. Mitchell		Dolores	Sorde	let	
Man	should be file and Mental F 7 is marked o raumatic eve			9b. Mailing Address (Street and No				
e, N	and 2 Health em 2: ther t		Sandra Gomeringer /sister	3 Hammock Tr	Date		MD Z I Z Location - City or	
mor	ent of i		1   Burial 2 □ Cremation 3 □ Removal from State  HOLI  Onestion 5 □ Other (Specify)	tery, crematory or other place) Ly Hill Cemet	ry 1/5/	12 Ba	altimor	e MD
Baltimore,	permit. Page 1 Department of Important: If i any injury or o		21. Signatury of Funeral Sarvice License	22. Name and Address of F	Facility 300 Funeral	Mace A	ve. Bal of Esse	to. MD x 21221
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.					Approximate Interval Between
	hysician/		Immediate Cause (Final disease or condition	Salero.	s Ĉ			Onset and Death
week!	Medical Examiner		resulting in death)  Due to (or as a consequence					
	od sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e of):				
	ate be executed physician and the burial-transit	Exar	Cause (Disease or injury that initiated events resulting in death) Last	e of):				
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6876	tificat ing ph e as th	Mec	IF FEMALE:					-
Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1  Live Birth 2 Fetal deady 4  Pregnant at time of death				23d. Date of deli Month	ivery Day Year
s, P.O.	v requires that t s been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in	Part I.			the cause of death?
of Vital Records,	requir been shoulk	Completed by				24a. Was an		topsy findings available
3ec	sician: The law in certificate has the lirector, page 2 s	omo				autopsy performed? 1 Yes 2	death?	completion of cause of
a	ysician: T s certifica director, p	Be C	25. Was case referred to medical examiner?		f Death (Check only			
Ξ	> .8 0	유	1   Inpatient 2   ER/ 27. Manner of Death   28a. Date of Injury   28b.		Nursing Home			ify)
0 U	fing After fune	cate	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year)	o. Time of injury at work?  M 28c. Injury at work?  1 □ Yes		Describe how inj	ary occurred	
Division	Il or Attending after death. Director: After d in by the fune	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)		28f. l	Location (Street a City or Town, Sta	and Number or Rui	ral Route Number,
<u>S</u>	ital or irs afte al Dir lled in				100			
	Mospital 24 hours a Funeral I etely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner; On the basis of examination and 3 Certifying Nurse Practitioner: To the best of my knowledge 2 Medical Examiner; On the basis of examination and 3 Certifying Nurse Practitioner: To the best of my knowledge 2 Medical Examiner; On the basis of examination and 3 Medical Examiner; On the best of my knowledge 2 Medical Examiner; On the best of my knowledge 3 Medical Examiner; On the best of my knowledge 3 Medical Examiner; On the best of my knowledge 3 Medical Examiner; On the basis of examination and 3 Medical Examiner; On the basis of	d/or investigation, in my opinion, de	ath occurred at the ti	ime, date and pla	ce, and due to the o	cause(s) and manner stated.
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	2	29b. Signature and title of certifier	29c License num		29d. E	Date signed (Month	n, Day, Year)
	)		1000	- 10/58	72	ca	m 32	012
			30. Name and address of person who completed cause of death (Item 23a	L'n Olur (	Hen &	unnit	m32	06/
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	barrel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 7:08 A M Kathleen M. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Min 366-52-4158 Director 1 🗆 M 2 🔀 F 62 Apr 23, 1949 Michigan at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 3a or 28a-f sh 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? ms 23a o Funeral 1211 Woodside Parkway United States 20910 "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 2 X No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Caucasian Year or Dates Health and Mental Hygiene. tem 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 Telecommunications Marketing Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Leonard G. Talbot Johnston Marion E. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Daniel Mink / Husband 1211 Woodside Parkway Silver Spring, MD 20910 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ò Department of Important: If it any injury or o once. 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 1/4/2012 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Soffice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or Injury The law requires that the death certificate be executed that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Fetal deat
Pregnant at time of death in the past 12 months?

1 Yes 2 XNo
9 Unknown Month Day Year 5 Other (specify) been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an page 2 s autopsy performed? Yes 2 No death? funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice ၉ 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined

Division of Vital or Attending Physician: To the Hospital 24 hours within 24 hor To the Fune completely f

(d

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 20855 Debrah Miller, CRNP Rockville. 6001 Muncaster Mill Rd. 31. Date filed (Month, Day,

State Registrar

Medical

29a. Certifier

(Check

29b. Signature and the of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

R143201

29d. Date signed (Month, Day, Year) 31

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mar	yland				/lental Hyg	iene		
			Registrar  1. Decedent's Name (First, Middle, La	ast)		Certi	ficate of D	Death	2. Date of Deat	eg. No. 2		3. Time of Death
	Physicia Medic			William	Jay	Mowbr	ay		Decembe		2ŎT1	11:30 p M
	Examin		4a. Facility Name (if not institution, giv			4		Location of Death		4c. Count	y of Death	
	Funeral		Gilchrist Cente 5. Social Security Number 6.		n yrs. last	birthday)	Tow If Under 1 Year_	SON  If Under 24 Hrs.	8. Date of Birth	B	altimo	Iace (State or Foreign
	Director			1 🏋 M 2 🗆 F	64	Yrs.	Months Days	Hours Min.	JAN 3,		Indi	ry)
	and show	o.	Usual Residence of Decedent  10a. State  10b. County	10		own or Locat	ion		0211 3,	1777		Od. Inside City Limits
	Maryla 28a-f otified	Director	MD Bal	timore		E	hoenix					1 ☐ Yes 2 🛣 No
	ith the	ralD	10e. Street and Number 2803 Merrymans	Mill Road			10f. Zip Code <b>21</b> 1	21	1	0g. Citizen of US		try?
	leath w	Funeral	11. Marital Status	12. Was Decedent Ever	r in U.S.	13. Wa	s Decedent of Hi	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No-	14. Ra	ce - America	
36	after c	d by	1 XNever Married 2 Married 3 Widowed 4 Divorced	If Yes, Give A			Yes 2 No		nican, etc./	Specif	ack, White, e	
2-00	hours matura dical E	Completed	15. Decedent's (Specify only highest g		1	16a. Deceder	it's Usual Occupa	ation	T	16b. Kind of I	Whit Business/Ind	
121	thin 72 ane. <b>than</b> "	Somp	Elementary/Secondary (0-12)	College (1-4 or 5+)		life. DO I	VOT use retired)	luring most of work		or Do	atal A	conou
1d 2	iled wi	Be	17. Father's Name (First, Middle, Last)			DLIV	er	18. Mother's Nam	e (First, Middle, M	Car Rei		igericy
ylar	uld be f Menta narked latic e	욘	John		lowbr	ay		Doro	othy		Fried	lline
ā <b>∑</b>	2 shouth and the and t		19a. Informant's Name/Relationship ( Scott P. Mowbray		- 1			and Number or Rura ${\sf SMill}$ Rc		oity or Town,		ode) 21131
ore,	of Hea of Hea fitem		20a. Method of Disposition		20b. Plac	e of Dispositi		1		20c. Location		
Baltimore, Maryland 21215-0036	регтіг. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 🕅 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	ify)	Metr	o Crem	atory,	Inc. 12/3			timore	
Ba	Depar Impor any in		21. Signature of Funeral Service Licer	See George Ma	cNab		lame and Addres	s of Facility Cr erick Roa				MD, Inc. 21228
			23a. Part 1. Enter the disease, or conshock, or heart failure. List only	nplications that caused the one cause on each line.	e death. [	o not enter t	he mode of dying	), such as cardiac				Approximate Interval Between
	h si ian Medical		Immediate Cause (Final disease or condition resulting in death)	a. Savano Due to (or as a co	u's c	ell Co	Janna	of hea	d and v	reck		Onset and Death
	Examiner		Sequentially list conditions,	b	- Trooquon	30 01)1						`
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequen	ce of):						
	ite be executed hysician and the burial-transit	Еха	that initiated events resulting in death) Last	C. Due to (or as a co	nsequen	ce of):				·		
09	ate be the shape of the but	dical		d								
687	oding partifications and the second s	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p						234 D	ate of deliver	D/
Box 687	death o	Physician/Me	in the past 12 months? 1  Yes 2 No	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown			ctopic pregnanc other (specify)	у				Day Year
P.O.	detach	, Phy	g Unknown  Part II. Other significant conditions		not resulti	ng in the und	erlying cause giv	en in Part I.	23e. Did tob	acco use con	tribute to the	e cause of death?
S, F	uires the n signerally all the n	ed by									1000	ably 4 🗆 Unknown
Records,	aw req las bee e 2 sho	Completed							24a. Was an		prior to con	sy findings available npletion of cause of
Re	n: The lifeate h		25. Was case referred to medical						perform 1  Yes 2	ied?	death?	2 🗆 No
Vita	Physician: T r this certifica eral director, p	To Be	examiner?  1 \( \sum \text{Yes}  2 \sum \text{No} \)  No	Hospital:	2 🗆 ER	/Outpatient	Otho	r: 4  Nursing Ho	k only one) ome 5 🗌 Resider	nce 6 XOtt	ner (Snecify)	hospi4
Division of Vital	ing Ph		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Ye	28	b. Time of injury	28c. Injury work	at	28d. Describe hov	-	, , , , , , , , , , , , , , , , , , , ,	
Sior	Attend r death cctor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not 1 4 Homicide determined	De Diago of Injuny	- At home	, farm, street		Yes 2 No	28f. Location (Str	eet and Numl	ber or Rural I	Route Number.
DIX	iral or irs afte al Dire		4 - Hornicide determined	building, etc. (S	(pecify				City or Town,			
	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending of completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Medical	(Check 2 L Medical Exam	vsician: To the best of my niner: On the basis of exam se Practitioner: To the be	nination an	id/or investiga	tion, in my opinio	n, death occurred at	the time, date and	place, and di	ue to the cau:	se(s) and manner stated.
_	To th To th COTTE	-	29b. Signature and title of certifier				29c. License	number	29	d. Date signe	ed (Month, D	ay, Year)
D			Clean	ws .		) (T		8203		Decem	her 3	0 2011
			30. Name and address of person who	completed cause of death	n (Item 23	a) (Type, Prin	nonce	, CF 7	200500	mo		
	Stat	· .	31. Date filed (Month, Day, Year)	32. Removar's	Signature	1 1		,				
	Registra	1	JANU3	WILL Street		. Ma	Kel					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State Registrar		Certifica	te of Death	R	eg. No. 201	42081
ĺ	Physicia Medic		1. Decedent's Name (First, Middle, La	St. Merlin	19		2. Date of Death	Day Year	3. Time of Death 9:24 AM
	Examin		4a. Facility Name (if not institution, give	street and number)	4b. Cit	y, Town, or Location of De	ath	4c. County of Dea	th
	Funeral		5. Social Security Number 6. S	7. Age (In yrs. last		er 1 Year If Under 24 H			rthplace (State or Foreign
	Director		2/8 -42 -7328 1 Usual Residence of Decedent	1 M 2 D F 67	Yrs. Months	Days Hours Mi	n. (Month, Day,	1944	ountry)
	land show dat	tor	10a. State 10b. County		Town or Location		1 - 1 - 1	7 7 7 7	10d. Inside City Limits
	Mary 28a-f	Sirec	MD		altimor	e City			1 Yes 2 No
	is filed within 72 hours after death with the Maryland tal Hygiene. Ed other than "natural", or items 23a or 28a-f show other, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 428 Folcir	oft Street	101. 2	21224		10g. Citizen of What C	ountry?
_	r death		11. Marital Status 1  Never Married 2  Married	12. Was Decedent Ever in U.S. Armed Forces? 1  Yes 2 No	13. Was Dec	edent of Hispanic Origin? ecify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whi	
მაიი-ი	within 72 hours after giene. er than "natural", or the Medical Exami,	ed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1 🗆 Yes	2 No Specify:		Specify: U	)hite
ה	72 hou n "natu fedica	Completed	15. Decedent's E (Specify only highest gi	Education 1 rade completed)	16a. Decedent's Us (Give kind of w life. DO NOT u	ork done durina most of w	vorking	16b. Kind of Business	s/Industry
717	within giene.		Elementary/Secondary (0-12)	College (1-4 or 5+)	Bar	OUNER		Self-El	nployed
and	ntal Hyg ed oth	To Be	17. Father's Name (First, Middle, Last)	100/10		18. Mother's N	lame (First, Middle, N	faiden Surname)	
⋝	should be fi and Menta is marked aumatic ev	ľ	19a. Informant's Name/Relationship (i	7	19b. Mailing Addre	ss (Street and Number or	Rural Route Number,	City or Town, State, Z	ip Code)
, Ma	1 and 2 should be if Health and Men item 27 is marke other traumatic		Kickelle Pars	BON - Daughke	1304	Providence	eRd.	TOWSON,	MD 21286
nore	or it o		20a. Method of Disposition  1  Burial 2  Cremation 3	Removal from State	ce of Disposition (Nametery, crematory or	ame of cother place)	/ /	20c. Location - City o	
saltimor	permit. Pag Department Important: any injury o		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Licen		22. Name a	and Address of Fility	124/2011 Bradbey	-ASLton	LORE, MY
מ	P P E B		Tithit	<del></del>	Home	PA, 2134	W111000=	5) ring k	
	Physician/		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	Do not enter the mo	ode of dying, such as card	iac or respiratory arre	st,	Approximate Interval Between Onset and Death
1	Medical		disease or condition resulting in death)	a. Due to (or as a consequen	nce of):				Years
	Examiner	eľ	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequen	ace off:				
	uted Id ansit	Examiner	cause. Enter Underlying Cause (Unsease or injury that initiated events	C.					
	ificate be executed g physician and as the burial-transit	alEx	resulting in death) Last	Due to (or as a consequen	nce of):				
00/9	ficate b g physi as the b	Medical		d					
Š	th certil tending or use		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	leath 3 🔲 Ectopi			23d. Date of d	
. Box	he dear y the at iched f	Physician/	1 Yes 2 No 9 Unknown	4 Pregnant at time of dea 9 Unknown	ath 5 🗌 Other (	(specify)		IVIOITII	Day Year
7.	s that t gned b be deta	ρ	Part II. Other significant conditions	contributing to death but not resulti	ing in the underlyin	g cause given in Part I.			to the cause of death?
ecords,	require been si should	eted	LIVET MASS				1	1	Probably 4 Vunknown autopsy findings available
Hecc	he law te has l	Completed					autops perfor	sy prior to med? death?	completion of cause of
Vital	cian: T ertifica ector, p	Be	25. Was case referred to medical examiner?	Hospital:		26. Place of Death (C		220,00	
010	Physi r this c eral dir	e: To	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 ER	8b. Time of	DOA Other: 4 Nursin		ence 6 Other (Spe	ecity) Hospice
00	ending eath. or: Afte the fun	ertificate:	Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be		injury M	work? 1 Yes 2 No			
IVISION	after de Directe	O	4 Homicide determined		e, farm, street, facto	ory, office	28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	edical		ysician: To the best of my knowled niner: On the basis of examination ar					
	o the Prithin 24 of the Foundation	Me		rse Practitioner: To the best of my I	knowledge, death or		d place, and due to th		as stated.
	- s + o		Balson			D006063		12/2/1	11/
			30. Name and address of person who						,
	Stat	te	BINDU TOSEPH 31. Date filed (Month, Day, Year)		AR LAN	E, COLUM	BIA MD	21044	<u> </u>
	Registra		JAN 0 3 2		1 100	j			

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42082 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ DEC. DONALD FREDERICK MILLER 26. 2011 3:20 P M Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER HARFORD BEL AIR . Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Mir 10777732 212-30-4233 1 🛣 M 2 🗆 F 79 MD Director Usual Residence of Decede 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No MD HARFORD ABINGDON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 3720 GOOD WILL CT 21009 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 9 þ 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the SUPERINTENDANT GENERAL MOTORS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is mediany injury or other? CHARLES GORDON MILLER ESTELLE A. SCHWANEBECK 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY MILLER-WIFE 3720 GOOD WILL CT ABINGDON, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State HIGHVIEW CEMETERY 12/30/11 FALLSTON, MD 4 Dopation 5 Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility SCRIMUNEK FUNERAL HOME OF BELATR Service Licenses 610 W. MACPHAIL RD BEL AIR, MD 21014 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Previous/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury -tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23d. Date of delivery 23b. Was decedent pregnant Division of Vital Records, P.O. Box 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 1 Yes 2 Hospital or Attending Physician: the funeral director 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 2000 Other: မ 1 Tes 1 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide work? 1 🗆 Yes 2 🗆 No iniury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 060768 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUHAMMAD JOKHADAK, 500 UPPER CHESAPEAKE DR, BEL AIR 21014

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year,

mooola555

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. AMEND AMEND State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Year 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Health Care - Perring Pkwy Ctr Parkville Baltimore | Honder 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1928 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1926 | New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months 009-16-6202 85 Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hyglene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Medical Examinar must be notified at once. Director Maryland 1 ☐ Yes 2XX No Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9409 Flagstone Dr. 21234 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1944-46 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced Specify: white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) electrical engineer 5 + coll.engineering 18. Mother's Name (First, Middle, Maiden Surname) **Margaret** Oden 17. Father's Name (First, Middle, Last) Be Arthur J. Markham 199. Informant's Name/Relationship (Type. Print) Drian L. Markham/son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2405 Peachstone Ct. Silver Spring, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory Dec. 29,2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland John O. Mitchell IV, Funeral Services of Dulaney Valley 21. Signature of Funeral Service Licensee John O. Mitchell 200 E. Padonia Rd. Timonium, MD 21093 23a. Pay . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shad, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Muanery /Medical Due to (or as a consequence of Examiner 01 mary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and the burial-tran resulting in death) Last Due to/(or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Dav 5 ☐ Other (specify) 1 Tyes 2 No. 9 Unknown à cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2 No 1 ☐Yes 2 ☐No After this certification, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation s after dea. 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 087625 Ecember 28, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Soulsm MD 21201 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Decembe Gloria Sterbini Melanson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Good Samaritan Hospital N/A Baltimore If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Director** 165-22-5986 1 □ M 2 **X** F 83 February 18,1928 Illinois Usual Residence of Decedent with the Maryland notified at 10a State 10h. Count 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Maryland N/A Baltimore 1 XX Yes 2 □ No 10e, Street and Number ò 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 5114 Norwood Rd. 21212 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. lan "natural", or iter Medical Examiner þ 1 Never Married 2 Married (0/0 N/9 / 1/8 / GD 50 D Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) i other than " Elementary/Secondary (0-12) College (1-4 or 5+) admissions coordinator retirement community Be Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Paul Sterbini Junita Azzara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mariale Hardiman/daughter 5804 Kipling Ct. Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗓 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Crematory Dec. 31,2011 Baltimore, Maryland 21. Signature of Funeral Service Licenses Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be Box 68760 as attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes No 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day Year 9 Unknown 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 2 🗌 No 1 🗌 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျ 1 Inpatient 2 ROutpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 28a. Date of injury (Month, Day, Year) Manner of Death After t Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ours after death.

leral Director: Af
filled in by the fu Accident Investigation М Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the beg only one) of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated MIDI completed cause of death (Item 23a) (Type, Print) s of person wh PLAVEN BLUD FALTIMORE, MD 21239 5601 LOCH JOSEPH MD

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2011 42085

		1-For State Registrar	Certificate of			eg. No.	1 7200	
Physic Podical Exam		1. Decedent's Name (First, Middle,Last)  Jesse Thomas Mo	cDermott		2. Date of Dea Month December		3. Time of Death 1415 hrs	
		4a. Facility Name (if not institution, give street and number) 3606 Kenyon Avenue	41	o. City, Town, or Location of Baltimore		4c. County of Death		
Funeral Director		217-27-5253 <sub>1</sub> XX <sub>M 2□F</sub>	yrs. last birthday) 22 yrs.	If Under 1 Year If Under 1 Months Days Hours		th(MM/DD/YYYY) 9. Birt 28,1989 Foreig Cou	hplace (State or n untry) Mary Land	
Varyland 28a-f show any 1 at once.	tor	Maryland Baltimore	City, Town or Locatio	Parkvill			10d. Inside City Limits 1 Yes 2 XXNo	
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	I Director	10e. Street and Number 9824 Harford Road		10f. Zip Code 21234		og. Citizen of What Cour Inited States C	•	
after death wit all", or items 2 necr must be 1	by Funera	11. Marital Status  1 Never Married  2 Married  3 Widowed  4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Yes 2 Never Married  14. Was Decedent Ever in Armed Forces?  1 Yes 2 Never Married  15. Was Decedent Ever in Armed Forces?  1 Yes 2 Never Married  16. Was Decedent Ever in Armed Forces?  1 Or	If Yes	Decedent of Hispanic Origins, specify Cuban, Mexican, Pres 2 X No specify:		White, etc.	aite	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. T's in marked other than "natural", or items 23a or 28a-f shu zumatie event, the Medical Examiner must be notified at once	Completed b	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12)  College (1-4 or 5+)		s Usual Occupation (Give kir st of working life. DO NOT us COOK	nd of work done se retired)	16b. Kind of Business/Industry Silver Spring Mining Co.		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 ho. Deparment of Fleath and Mental Figuere. Important: If item 27 is marked other than "ani injury or other traumatic event, the Medical Exa	Be	17. Father's Name (First, Middle, Last)  Thomas Patrick Mc				e Rumsley		
MD 21 d 2 should 1 tth and Men n 27 is man	2	19a. Informant's Name/Relationship (Type, Print)  Thomas Patrick McDermott — Father		Address (Street and Number Arford Road, Par			Zip Code)	
Baltimore, Permit. Pages 1 and Department of Healt Important: If item injury or other trau		1 Burial 2 XXCremation 3 Removal from State	vans Funeral	on (Name of cemetery, rplace) Chapel and vices-Belair	Date Dec 31, 2011	20c. Location - City or Forest Hill,		
Balti permit. Departm Imports injury c		21. Signature of Funeral Service Licensee	22. Na EVa	me and Address of Facility ins Funeral Chape 10 Harford Road,	el and Cremat Parkville, M	ion Services -		
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line.  Immediate Cause (Final disease a. <b>Heroin Intox</b>	eath. Do not enter the	mode of dying, such as card	diac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death	
	<u>.</u>	or condition resulting in death)  Due to (or as a consequence because if any, leading to immediate to consequence because if any, leading to immediate to consequence because it any, leading to immediate to consequence because it is a consequence because						
od sit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
'60, cate be executed physician and the burial - transi	Medical	x UNPENDED  X AMENDED 23a, 27, per me.	28a-f.pe	me,g923 1-9	-12 sm			
ox 687 ath certific attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of 9 Unknown	regnancy 2 D Fetal	death 3 Ectopic pr		23d. Date of delivery Month D	ay Year	
P.O. B es that the de igned by the	Š	Part II. Other significant conditions contributing to death but no	ot resulting in the unc	derlying cause given in Part I		bacco use contribute to the co		
of Vital Records, P.C. ng Physician: The taw requires that Wher this certificate has been signed I meral director, page 2 should be deta	Completed				24a. Was a autops perform	sy prior to co med? death?	opsy findings available impletion of cause of	
Vital   hysician: this certified director,	To Be (	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2	ER/Outpatient	26.Place of Death (Ch 3 DOA Other N		Residence 6 🗸 Other.	Scene	
_ = = 1 ≥ = 1	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident Prestigation  1 Natural 5 Pending Investigation  1 Natural 5 Pending Investigation Investi	28b. Time of Inju	To Yes 2 X No		ow injury occurred		
Division spital or Attendii hours after death.	Certification:	Suicide 4 Homicide determined (Specify) Fr	iend's hou		Baltimo			
Di To the Hospital of within 24 hours a To the Funeral I	edical	29a. Certifier 1 Certifying Physician: To the best of my knowl one) 2 Medical Examiner: On the basis of examination and manner stated						
	Ž	29b. Signature and title of certifier  Paymun Gouthaul, MD		29c. License number O.C.M.E.		29d. Date signed (Moni December 29, 20		
		30. Name and address of person who completed cause of death (Itt Pamela E. Southall, MD Assistant Medical Ex	xaminer 900 V	V. Baltimore Street, B	Baltimore, MD 21	223		
St Regist	ate	31. Date filed (MongAN 0ar 3 2012 32. Registrar's Signa	ature A	r.l				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 42086 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 30, 2011 3:05 A M William Joseph Maher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Montgomery Hospice Casey House Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Days Hours Min (Month, Day, Year) 334-26-8756 Director 1 X M 2 D F 76 Dec. 28, 1935 Illinois Usual Residence of Decedent 28a-f shov Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Silver Spring Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral 20906 United States 2810 Atlanta Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married X Yes 2 ☐ No f Yes, Give Completed by Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 □ Divorced White Unk. Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 18b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Nuclear Regulatory Elementary/Secondary (0-12) College (1-4 or 5+) Commission Senior Editor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bonnie Burns James Maher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health a item 27 i 14100 Whispering Pines Ct. #31, Wheaton, Maryland 20906 Michele G. Maher/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State December 30, Montgomery Crematorium Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signature of Funeral Service Licensee fan willian smes M01173 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Carcinoma with Unknown Primary disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Exami burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No g Unknown 9 Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed been signated 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2 💢 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice ဂ္ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: eral Director: After filled in by the funer injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 🛚 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0060634 December 30, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bendu Joseph, M.D. 1355 Piccard Drive #100, Rockville, Maryland

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42087 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Genette Maney Month Day Vear 9:15 A M Deumber Medical 20 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore **Examiner** 4b. City, Town, or Location of Death Randallstown Seasons Hospice . Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 223-42-4195 Director 1 🗆 M 2 💢 West Virginia Nov13,1932 79 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore City 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21224 417 North Robinson Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2XXMarried Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: White Specify: Completed 3 Widowed 4 Divorced John July Montal Hygiene.

is marked other than "natural" is marked other the Medical Expression of the Medical Expression Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Shoe Manufacturing 8th Inspector (unk) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 417 North Robinson Street Baltimore,Md21224 Page 1 and 2 <u>Bobby M. Maney</u> / Husband Baltimore, 20a. Method of Disposition January 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or o once. ō Oak Lawn Cemetery 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 3,2012 Department 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, M00933 1201 Dundalk Avenue Baltimore, MD. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Card 10 Phrombotic Brent Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 this certificate 2 No **Division of Vital** To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Other: 1 Tyes 2 3 No Certificate: To 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending work' 1 Tyes 2 Accident
3 Suicide Investigation 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Ms Ryapahlm.D 29d. Date signed (Month, Day, Year) 10057465 12/29/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N.S. RYMPAKSE MID 2835 Smin N Baltimore MD 21209 5703 N.S. Rajapakse MID 31. Date filed (Month. State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 42088 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Jacob Noves Month December 2011 2:00 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 x M 2 □ F Hours (Month, Day, Yea Months Days 216-30-3525 82 Yrs Director 929 Usual Residence of Decedent 10a. State 10b. County death with the Maryland ms 23a or 28a-f shorms the restrict of the res 10c. City, Town or Location 10d. Inside City Limits Director MD Sykesville Howard 1 ☐ Yes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1100 Day Road 21784 ural", or items ? I Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If then 27 is marked other \*\*.

any injury or other trainments. was becedent Ever in U.S. Armed Forces? 1 1 2 Yes 2 No Korea If Yes, Give Year or Dates. Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify. Specify: white Completed 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) agriculture farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Grace Anna Markley John Harvey Winfred Noyes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 724 Central Ave., Sykesville, MD 21784 Linda Chaffman (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial 1-4-12Svkesville,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licensee Jos P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence on): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami the attending physician and hed for use as the burial-transil Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death 2 🗌 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 🗌 No Yes 2 Hospital or Attending Physician: 24 hours after death. **Director:** After this certificd in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No SOLY မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Doath 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 🗷 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29d. Date signed (Month, 30

Registrar

DHMH 17 Rev 7/2009

State

Date filed (Month, Day,

Year)

WESTMINSTER NO 2115

person who completed cause of death (Item 23a) (Type, Print)

355

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #29cc30 Per DVR G923 1/03/2011 JH. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 201 42089 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30 Pay 201 eq De Coth Physician/ Christopher G. Oktavec 3:00 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Middle River 1322 Goose Neck Road Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Min. Oct. 28, 1946 216-50-0687 Months Hours 65 **Director** 1 🛛 M 2 🗆 F Yrs Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Baltimore MIddle River MD 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21220 USA Funeral 1322 Goose Neck Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after White nan "natural", o If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72. In and Mental Hygiene. Is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) A.Oktavec &Son the Painting Contractor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury over any 2 Theresa Michael Albert Oktavec 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore MD 21220 1322 Goose Neck Road Charlotte Oktavec/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Gardens of Faith 1/4/12 Rossville MD 4 Doriation 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 21. Sigry Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Retween Onsbj. of Teat Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year 1 Yes 2 9 Unknown been signed by the a should be detached t 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Chronic Renal Farous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 perform 1 Yes 2 No Director: After this certificate Yes 2 25. Was case referred to medical the funeral director. 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 1 Nursing Home | 5 \( \text{Nesidence} \) Residence | 6 \( \text{Other} \) Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 \square Yes 2 \square No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D

completely filled Medical t Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 1D32453 Camo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 Shilling RD Mark Lamos Hunt Valley MD 21031 31. Date filed (Month, Day, Year) 2. Registrar's Signa State JAN 0 3 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State of Marylan & Department of Health and Mental Hygiene	
		1 - State Registrar Certificate of Death Reg. No. 2	42091
Dhusi-i	/	Month Day Year	. Time of Death
Physicia , Medi		SAMUEL MORE OBIEMEKE 12 18 2011 0	5:25 M
Examin	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
and the same of th		Mount Washington Pediatric Hospital Baltimore NA	
Funeral		Months Days Hours Min. (Month, Day, Year) Country)	State or Foreign
Director		213-91-9450 Yrs. 7/3 05/05/2011 Usual Residence of Decedent	<u> </u>
and show	b		Inside City Limits
Maryland 28a-f show otified at	Director	MD Baltimore Parkville	1 🗌 Yes 2 🗷 No
the I		10e. Street and Number   10f. Zip Code   10g. Citizen of What Country?	
nd 21215-0036 filed within 72 hours after death with the Maryland al Hygiene. Jother than "natural", or items 23a or 28a-f showert, the Medical Examiner must be notified at	Funeral	2913 Andorra Ct. 21234 USA	
death item		11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	ndian,
36 after after camin	g	1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Place	k
21215-0036 within 72 hours after giene. then "natural", o tre Medical Exam.	Completed	Total of Dates.	
72 h	ם	(Specify only highest grade completed) (Give kind of work done during most of working	T y
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illed v all Hyg lothe	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
/lar d be 1 Ments arked	욘	Grea Obiemeke Josephine AFuwape	_
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informa Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code	e)
nd 2 sealth		Greg Objemeke-Father 2913 Andorra Ct. Baltimore, MO 2123	4
Ore of Hiter		20a. Method of Disposition  20b. Place of Disposition (Name of Date 20c. Location - City or Town, Cemetery, crematory or other place)	
Limo Page ment o tant: If		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Neral Service Licensee  22. Name and Add ess of Facility March FH East 1101 E. No	)
Baltimore, permit. Page 1 and Department of Hed Important: If item any injury or othe		21. Signature of the eral Service Licensee 22. Name and Address if Facility March FH East 1101 E. No	th Ave.
		Baltimore, MD 21202	
		about or boart failure. List only one course on each line	pproximate erval Between aset and Death
Phy i i n Medical		disease or control ARSPIRATORY FAILURE	iset and beaut
Examiner		Due to (or as a consequence of):  HYPOXIC /SCHEMIC ENCEPHALOPATHY  7	صرات
	ē	Sequentially list conditions if any, leading to immediate Due to (or as a consequence of):	77120
ed	Examiner	Cause (Disease or linjury  VENTILATOR DEPENDENT	
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760 cate be executed physician and the burial-transit	dical		
376 ficate g phy as the			
Box 687 death certifica ne attending p	Jug I	IF FEMALE: 23b. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   1	
30) death re attr	sici	1   Pregnant at time of death   5   Other (specify)   Month   Day	y Year
ords, P.O. Be requires that the der been signed by the should be detached	Physician/M	9 🗆 Onknown	
s that gened be de	ğ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the conditions contributed to the conditions contributing to death but not resulting in the underlying cause given in Part I.	
ds.	ted	13 13 2210 03 1000	ly 4 🗌 Unknown
COL aw re as be	ple		findings available etion of cause of
<b>Re</b> The I	Completed by	performed?	2No
tal cian; ertific	Be	25. Was case referred to medical examiner?  Hospital:  Other:	
f Vi	<u>و</u>	1 Inpatient 2 Sec/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)	
ding F	Certificate:	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury work?	
SiOI ttenc deatl deatl y the	iji Iji	3 Suicide 6 Could not be 29. Place of lainty. At home farm street feature office.	ute Number
Division of Vital Records, all or Attending Physician: The law requires is after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be an in the funeral director.		4 Homicide determined building, etc. (Specify)	
Spita spita neral	ical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(	
To th Withii To th	-	29b. Signature and title of certifier 29d. Date signed (Month Day,	
	1	12/20/20 12/20/20	11

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1708 W. ROBERS

State

Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Oldaker, Jr. <u>4:15</u>₽<sup>™</sup> 26 2011 Joseph Samue1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie 401 King George Drive Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Hours **Director** 232-84-2533 1 XM 2 □ F 59 Yrs. WV 02/21/1952 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County death with the Maryland 10a. State 10c. City, Town or Location Director 1 Yes 2 X No Glen Burnie MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or ner must be n ö Funeral 401 King George Drive 21061 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces?

1 Yes 2 XNo "natural", or by 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced White Completed the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Ith and Mental Hygiene
27 is marked other the
traumatic event, the Construction 12 Project Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Samuel J. Oldaker, Sr. permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Wilda Means 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061 Glen Burnie, MD 401 King George Drive, Mrs. Mary E. Oldaker / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/02/2012 Glen Burnie, Maryland Atlantic Crematory Signature of Funeral Service License 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD M01357 Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician retistan disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence oi). Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 2 **O** No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA ျ this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 4 hours after death.

\*uneral Director: Aft
ely filled in by the fur 1 Tyes 2  $\square$  No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 3 🗆 29b. Signature and title, 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address

JAN 0

DHMH 17 Rev 06-2011

PAK-wood Road 6 lan Burnie

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

WP

3 2012

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21061

11-09537 Rodney Vest Pridget	Please Type	or Print in Black Inc	delible Ink. Ensure All	Copies Are Legi	ble.	
. 1	l- For State Registrar		tment of Health and Me ificate of Death	ental Hygiene Reg.	No. 201	1 4209
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, L Roghey Ve	st Pridge	Pridget	2. Date of Death	oav Year	3. Time of Death 1830 hrs
	4a. Facility Name (if Not institution, g 825 Dulaney Valley Rd	live street and number)	4b. City, Town, or Location Towson	n of Death	4c. County of Death Baltimore Cou	
Director	218-35-5710 1	Sex 7. Age (In yrs. las	if Under 1 Year If Ur Months Days Hor		MM/DD/YYYY) 9. Bird Foreig Con	
w any	Usual Residence of Decedent  10a. State 10b. County  10e. Street and Number		own or Location  Him ore 10f. Zip Code	1100	. Citizen of What Cour	10d. Inside City Limits 1 Yes 2 No
with the Maryland s.23a or 28a-f sho e socified at once ral Director	3007 E. Bid	12. Was Decedent Ever in U.S.	21213		US A	
s after death with rral", or items 23 <u>niner must be an</u> by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorce	Armed Forces?  1 Yes 2 No ad If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexic	an, Puerto Ricán, etc.)	White, etc.  Specify: B/a	ack
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygies within 72 hours after death with the Maryland teem 21 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Furneral Director	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. Decedent's Usual Occupation (Given during most of working life. DO NO NOTAL DESCRIPTION OF THE PROPERTY OF THE PROPERT	ve kind of work done  T use retired)	6b. Kind of Business/li	ndustry
e, MD 21215-0036 I and 2 should be filed within 7 Health and Mental Hygiene. Titem 27 is marked other than r traumatic event, the Medica	17 Father's Name (First, Middle, La: Rodney V. 19a. Informant's N. me/Relationship	Pridaet	19b. Mailing Address (Street and N	er's Name (First, Middle, Mai	en	Zin Code)
9	Norma Palme 20a. Method of Disposition	-Grandmother	ace of Disposition (Name of cemetery, ematory or other place)	Baltimore M.	20c. Location - City or	
Pag Pag ant:	1 Burial 2 Cremation 3 4 Donation 5 Other Special 21. Signature of Funeral Service Light	by:	t. Zion  22. Name and Address of Faci	12/28/2011 March F/H 10 21202	Lansdown East 1101	n, MD E. North Ave
/Medical	failure. List only one cause on	nplications that caused the death. Deach line.  a. Multiple Gunshot Wound Due to (or as a consequence of):		s cardiac or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of):				
	events resulting in death) Last	Due to (or as a consequence of):	.022 1 2 12			
, in	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	AMENDED I per me  23c. If yes, outcome of pregnat  1 Live birth  4 Pregnant at time of deat	ncy 2 Fetal death 3 Ecto	pic pregnancy	23d. Date of delivery Month D	ay Year
of Vital Records, P.O. Box 68760, of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate by the attending physineral director, page 2 should be detached for use as the but it. To Be Completed by Physician/Mec	1 Yes 2 No 9 Unknow	9OHKHOWH	Other (Specify)  ulting in the underlying cause given in	_	cco use contribute to t	
Records, P.O. Bo): The law requires that the death ficate has been signed by the att, page 2 should be detached for Completed by Physical				24a. Was an autopsy performe	prior to co	ably 4 Unknown topsy findings available completion of cause of
of Vital Recing Physician: The After this certificate tuneral director, page on: To Be Con	25. Was case referred to medical		26.Place of Deal	1 ✓ Yes 2 th (Check only one)		s 2 No
F Vita	examiner? 1 ✔ Yes 2 No		R/Outpatient 3 DOA Other [4]	Nursing Home 5 Re	sidence 6 🗸 Other:	Scene
Division of Vital   To the Hopital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director. edical Certification: To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident Investiga	FOUND: Day,Year)  Dec 19, 2011	8b. Time of Injury 28c. Injury at Work 1 Yes 2 1	✓ No Subject shot		
Division To the Hospital or Attent within 24 hours and Directors To the Funeral Directors completely filled in by the edical Certification	3 Suicide 6 Could no determin 29a. Certifier	ed (Specify) Sidewalk	e, farm, street, factory, office building,	or Town, Stet 825 Dulaney Val	e) lley Rd, Towson, Mi	
3 \ 2 \ 8   8 L	(Check only 1 Certifying Physi		, death occurred at the time, date and p //or investigation, in my opinion, death of 29c. License number	occurred at the time, date and		cause(s)

DHMH 17 Rev 1/2001 OCME 2006

31. Date filed (Month, Day, Year) State Registrar

30. Name and address of person who completed cause of death (Item 23a)

Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 20, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42094 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ David Timothy Picciotti 7:30 AM 28 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 6525 Mink Hollow Road Highland Howard Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Hours 282-56-2569 Director 1**X** M 2 □ F 46 April 16 1965 OH Usual Residence of Deceder 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Howard Highland 28a-f 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 6 10g. Citizen of What Country? 23a 6525 Mink Hollow Road 20777 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Marital Status 14. Race - American Indian. Examiner Black, White, etc. o γ 1 Never Married 2 X Married 1 Yes 2 XNo
If Yes, Give
Year or Dates. Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. "natural", Completed 3 Widowed 4 Divorced white Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) the 6 executive security manager security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur L. Picciotti Patricia E. Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health an: If item 27 is Mrs. Susan Picciotti (spouse) 6525 Mink Hollow Rd., Highland, MD 20777 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State ō Department
Important: It
any injury or Mark's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1-3-2012 Highland, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel ut Herbert Harge Hara P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Sinset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) **Examine** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ★ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 2 No 1 Yes Division of Vital Hospital or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 2 No 욘 1 Inpatient 2 I ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death. e Funeral Director: Aft bletely filled in by the fur Accident M Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2.

To the F only one 29b. Signatur 29d. Date signed (Month, Day, Year) DIRECTOR, 023675 12/28/2011 auturn MEDICIA ONOLO GY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hiplims Cucer Couter CIM State Registrar

DHMH 17 Rev 06-2011

			State Registrar			Cer	tificate	of De	ath		Reg. N	lo.			
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	amin		4a. Facility Name (if not institution, give				4b. City, To	own, or Loc	cation of De	ath	4	c. County of	Death		÷
			Good Samaritan	Hospital				Balt	imore						
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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	/ inj	ı	21. Signature of Funeral Service Licens	ee	100124				-	chimunek				Inc.	-
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1144 NOVE	2000		shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.									- In	nterval Between Onset and Death	
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Box 68760 death certificate be executed the attending physician and	g L	Medical		d									$\bot$	<u>.</u>	
8760 tificate b ing physi	ast	Ě	IF FEMALE:								1				_
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Box death o	90 10	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at 9 ☐ Unknown			Other (spec					Month	D	ay Year	
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DIVISION Of VITAL RECORDS, all or Attending Physician: The law requires s after death.	g pin									_ 1 🗆	Yes 2	! □ No 3 [	☐ Probal	biy 4 Unknown	
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IVISION Of VITAL  I or Attending Physician: after death. Director: After this certific.	In by the funeral director,	Certificate;	4 Homicide determined	28e. Place of Injur building, etc.		, farm, stre	et, factory, of	ffice		28f. Location City or To			r Rural Ro	oute Number,	
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To the Hospital or A within 24 hours after To the Funeral Direct	completely filled	Medical	29a. Certifier (Check 2 Medical Examin	ician: To the best of n	ny knowledg	ge, death or	ccurred at the	e time, dat	te and place	, and due to the	ause(s) a	and manner a	as stated.	o(e) and mann	سد
the F nin 24	ubiet i	Δe	only one) 3 Certifying Nurs	e Practitioner: To the	best of my k	nowledge,	death occurre	ed at the tin	ne, date and	place, and due to	the caus	e(s) and manr	ne cause ner as stat	ted.	J.
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			30. Name and address of person who c		ath (Item 23	a) (Type, Pr	int)								
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	State		31. Date filed (Month, Day, Year)	32 Registrar							- 1			- 1	_
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 42096 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 31.2011 **Physician** Lillian Z. Piekarski December 7:35P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Franklin Woods Center Rosedale Balto. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 7. Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√□ F October 12,1907 217-09-0898 104 Yrs. **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumatic svent, the Medical Examinar must be notified at 1 X Yes 2 □ No Director Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 7137 Willowdale Avenue 21206 USA Funeral "natural", or itams 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after dial Hygiene. other than "natural", or itam 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify: White ð 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 5 th College (1-4or 5+) Seamstress Tailoring Pages 1 and 2 should be filed venent of Health and Mental Hygie ant: If Item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Stanislaus Zysk Frances Kalata 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard Piekarski Son 7137 Willowdale Avenue Balto.Md. 21206 epartment of Ht important: if Item any injury or other 000. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary 1-5-2012 Dundalk, Md. <sup>¹</sup> 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 21. Signature of Funeral Service Licenses 6415 Belair Road Baltimore, Md. 21206 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NEUMONI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Box 68760 certificate be Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐ Pregnant at time of death P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2 11116 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 No Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Tes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospitel or Attending Natural 5 Pending investigation death. 1 🗌 Yes 2 🗆 No 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospitel within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar FRANKLIN SQUARE DR. BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9105 F

PARSHALL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 1 2 Year Wilfred Paxson 2011 1:36 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Muntgomen Olne seneral HUSDITA 5. Social Security Number If Under 1 Year If Under Months Days Hours 8. Date of Birth (Month, Day, Nov • 30 **Funeral** Age (In yrs. ast birthday) 9. Birthplace (State or Foreign 1 X M 2 □ F Days 577-30-5516 Director 84 Nov. 1927 Washington D.C. Usual Residence of Deceden iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d Inside City Limits Director MD Montgomery Rockville 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4110 Heathfield Rd. 20853 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: item 27 is marked other than "natural", other traumatic event, the Medical Exa 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Handyman Various 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည Paxson Edith Port 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4110 Heathfield Rd., Rockville, MD Wilfred Paxson / Self Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) (Unk)Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Forestville, MD Epiphany Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Se Rapp Funera-933 Gist Ave., M00382 Name and Address of Facility Lapp Funeral and Cremation Services Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration neumonia disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
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DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type

32. Registrar's Signature

31. Date filed (Month, Day, Year)

JAN 0 3 2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle, Last) 2. Date of Death Physician/ Medical 4a Facility Name (if not institution, give etre **Examiner** 4c. County of Death **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 □ M 2 F Director Pennsylvania 21 1931 28a-f show an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 2002 Eagle Street U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
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Year or Dates. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 I and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Robert Stanley Madeline Gutshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or are 904 Lauren Way Hayden Pingley - Son Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🖵 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National 01/03/12 Baltimore, GJ Gonce Funeral Home, P 21. Signature of Euneral Salvice Licensee 22. Name and Address of Facility 169 Riviera Drive 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Basal Immediate Cause (Final Onset and Death Physician/ el arunomes disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗌 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) npletely filled in by the funeral 27. Manper of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: Al Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 3 only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of d Name/and address of per

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PONDFIELD 1346 SELMA, 12 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MEDICALENTE UNIVERSITY OF MARYLAND BALTIMORE N/A Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Hours 218-26-6550 Director 1 M 2 X F 82 05/06/1929 MD Usual Residence of Deceder 28a-f shov 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No MD BALTIMORE PIKESVILLE 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 4 CANDLEMAKER COURT, #401 21208 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. "natural", Specify: 3 X Widowed 4 ☐ Divorced Completed WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) **1**2 BUSINESS OWNER CLOTHING RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental is marked ပ JOSEPH AMERNICK FLORENCE SIEGEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh nt of Health a : If item 27 is SUSAN PONDFIELD / DAUGHTER 1227 JOHNSTON DRIVE, WATCHUNG, NJ 07069 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ARL'INCTON CEMETERY CHIZUK AMUNO 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or injury or 12/29/2011 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ASPIRATION PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner METABOLIC TOXIL ENCEPHALDPATHY Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence oi) Due to (or as a consequence of). resulting in death) Last Physician/Medical P.O. Box 68760 the phy as attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year the a 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Cardiomyopatty Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has to page 2 s autopsy performed certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 28a. Date of injury (Month, Day, Year) n 24 hours after ueau... ne Funeral Director: After th anletely filled in by the funera 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one 29b. Signature and the 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

D69490

University of MD Medical Center, 22 S Greene St, BALTIMORE, MD

12/27/201

GANJI

32. Registrar's S' ature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11-09683

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	en r c	etronier	Ü	1- For State Registrar	tate of Maryla		artment of e <mark>rtificate</mark> of		nd Ment	al Hygiene	Reg. No.	20		1 4210
Mei		Physici I Exam		1. Decedent's Name (First, Mide					·	2. Date of Month	Death Day nber 25, 2	Year		3. Time of Death 1645 hrs
i i i	uica	LAdili	11161	Helen V.  4a. Facility Name (if not instituti		tronie mber)		4b. City, Town, o	or Location of			2011 : County of	Death	1045 1118
				310 Elrino Street				Baltimore						
		uneral irector		5. Social Security Number	1 - 1	7. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Under	24Hrs. 8. Date	of Birth (MM/	DD/YYYY)	9. Birtl Foreigr	nplace (State or Mary Land
		Hector		213-16-4124 Usual Residence of Decedent	1 M 2 F	89	Yrs			Aug	5,192	2.2	Cou	intry)
		any		10a. State 10b. County		10c. City	, Town or Locati	on					Т	10d. Inside City Limits
	pu d	MOIF, MID 27275-50036 Pages I and 2 should be filted within 72 hours after death with the Maryland cent of Health and Mental Haygiene. utt. If titem 27 is marked other than "matural", or items 23a or 28a-f show any re other traumatic event, the Medical Examiner must be notified at once.	5	Md.		Bal	timore	City	7					1 X Yes 2 No
	Man		Director	10e, Street and Number				10f. Zip Code			10g. Citi:	zen of Wha		try?
	it th	s 23a c	a D	310 Elrino S		edent Ever in U	I.S. 13 Wa	2122 s Decedent of H		n? ( Specify Yes	or No-	U.S.		an Indian, Black,
	death v	r item	Funeral		Married Armed Fo					Puerto Rican, etc.		White,		arringari, black,
	2 after	ral", o	by F	-	vorced if Yes, Give Year or Dates:			Yes 2 N				Specify:		hite
	2 hour	"natu	ted	<ol> <li>Decedent's Education (Spe Elementary/Secondary (0-12)</li> </ol>			16a. Deceden	rs Usual Occupa ost of working lif	ation (Give kii e. DO NOT u	nd of work done se retired)	16b. K	and of Busi	ness/In	idustry
	036	r than	Completed	10th		,	Но	me Mak	er			)wn H	lome	е
	15-0 filed	or most when the found and the Hygiene.  **Red other than "natural", ent, the Medical Examiner.		17. Father's Name (First, Middle	, Last)				100	Name (First, Mide		Surname)		
	21215-0036	Mental marked c event,	To Be	John Wronka 19a. Informant's Name/Relations	ship (Type, Print )		19b. Mailing	Address (Stre	Mary et and Numb	7 Slab er or Rural Route		ty or Town,	State,	Zip Code)
	MD MD	Ith and 27 is	0	Vincent J. P	etronier		3758	E. Par	k Ave	enue Ph	oenix	Az.	8.	5044
	ore,	Department of Health a Important: If item 27 injury or other traum		20a. Method of Disposition  1  Burial 2 Cremation	n 3 Removal fro		Place of Disposi crematory or oth			Date Decembe		ocation - C		•
	Baltimore,	rtment rtant: y or of		4 Donation 5 Other S 21. Signature of Funeral Service		Oa M009	k Lawn							,Maryland
	Ba	Depa	ļ.	The Day	Licenson	M009				Avenue				Home, PA Md.21222
		sician		23a. Part I. Enter the disease, or failure. List only one cause		used the death							,	Approximate Interval Between Onset and
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		ion of vital Kecords, F.O. Box 66/60, heading Physician: The law requires that the death certificate be executed leath.  for: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transit	iner	if any, leading to immediate	Due to (or as a	consequence o	of):							
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	<b>50</b> , te be e	nysiciau e burial	Medical	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delive									liven	
	687 ertifica	e attending phys for use as the b	lan/N	23b. Was decedent pregnant in the past 12 months?	he 1 Live bir	th	2 Fet	al death 3	Ectopic p	eregnancy		Month	Da	y Year
	Box 6876	the atten ed for us	Physician/M	1 Yes 2 No 9 Un	known 9 Unknov	nt at time of de vn	5 Oth	er (Specify)						
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	Re The	his certificate director, page		25. Was case referred to medica				26 Place	of Death (C		es 2 No	1 🗸	Yes	2 No
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	of Ing P	After t funeral		27. Manner of Death  1 ✓ Natural 5		f Injury Day,Year)	28b. Time of In	· ·   _ ·	ıry at Work?		ibe how injui	ry occurred		
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	Div To the Hospital or	within 24 hours after death  To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying P	hysician: To the best									
_	Toth	within 24 h To the Fur completely	Medical	one) 2 Medical Exa 29b. Signature and title of certifie	miner:On the basis of and manner sta		nd/or investigation	29c. Licens		rred at the time, d				` ′
				1 1 1				O.C.				ember 28		h, Day, Year)
	•		ŀ	30. Name and address of person	who completed cause	of death (Item	23a)							
1	61				nt Medical Exam			Street, Bal	timore, M	D 21223				
		St Regist	ate	31. Date filed (Month, Day Year)	3 2012 32. Re	Istrar s Signatu	ire /	4.1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of	f Marylan	_	artment of F		Mental Hy	giene	0.1	,		101	
			Registrar  1. Decedent's Name	(First, Middle, L	ast)		Cer	tificate of E	<i>Death</i>	2. Date of De	Reg. No.		4	14/	LUI	
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-	<i>F</i>		1425 Cla					Haletho	-		Balt			re		
	Funeral Director		5. Social Security Nu			7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		B. Date of Birth (Month, Day, Year)			Birthplace (State or Foreign Country)		
			217-24-04 Usual Residence o		1 <b>XX</b> M 2 □ F	81	Yrs.			Feb. 1	0,1930	) Ma	ry1	and		
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á,	and 2 Healt tem 2		20a. Method of Disp		ey-wile	20b. F		sition (Name of		Date	20c. Locat					
Baltimore, Maryland	age 1 ent of nt: If i	ı		☐ Cremation 3 5 ☐ Other (Spe-	Removal from	State C	emetery, cren	natory or other place edral Cer	e) !	9,2011						
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89	certific nding   use as		IF FEMALE: 23b. Was decedent i	pregnant	23c. If yes, outo	come of pregna	ncy				220	. Date of c	dolivon			
Box 68	requires that the death certific been signed by the attending p should be detached for use as	Physician/M	in the past 12 n	nonths?	1 ∐ Live E 4 ☐ Pregr	Birth 2 ☐ Feta ant at time of a	aldeath 3 <u>L</u>	Ectopic pregnanc Other (specify)	у	-	230	Month	Di		ar	
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rds	equire een s hould	eted								1 🗆	Yes 2 🗆 I					
၀၁	has b	Completed								24a. Was auto		4b. Were a prior to death?	o comp	y findings ava pletion of cau	ailable use of	
ř	sician: The law certificate has b lirector, page 2 s		25. Was case referre	ed to medical	1			OC DIA	ace of Death (Chec	1 \( \text{Yes}	2 X No		es 2	□ No		
Zita Zita	ysicia s cert direct	To Be	examiner? 1  Yes 2	_	Hospital:	npatient 2 🗆	EB/Qutpatien	Othe	,		dence 6 🗆	Other (Sp.	ocifu)			
o	ng Ph fter th		27. Manner of Death	5 Pending	28a. Date of		28b. Time of injury	28c. Injury work	at	28d. Describe I			cony			
<u>o</u>	tendii Jeath. tor: Al the f.	ifica	2 Accident 3 Suicide	Investigati	ion			M 1 □	Yes 2 No							
Division of Vital Records, P.O.	or At after o Direct	28a. Date of injury (Month, Day, Year)  28b. Time of injury at work?  1 Natural 5 Pending (Month, Day, Year)  28b. Time of injury at work?  1 Yes 2 No  28c. Injury at work?  1 Yes 2 No  28d. Describe how injury occurred injury at work?										mber or F	Rural Ro	oute Number	r,	
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	To the Hospital or Attending Physiciam: within 24 hours after deals.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check 2 only one) 3	☐ Medical Exa	miner: On the basi urse Practitioner:	s of examination To the best of r	n and/or invest ny knowledge,	igation, in my opinio death occurred at th	n, death occurred a ne time, date and pla	t the time, date a ace, and due to	and place, and the cause(s) a	due to the	e cause r as stat	(s) and mann ed.	ner stated.	
	Not to t		29b. Signature and t	04 -	Λ			29c. License			29d. Date si					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Richardsu 5:12 AM **Physician** 2011 (ecamber /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 9. Birthplace (State or Foreign Country) Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 X M 2 □ F Hours Min 216-36-447 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified an once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 ☐ No Baltimore Directo 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 2/2/3 USA Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black ρ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Semblu Bethlehen Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hhnie ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant' ame/Relationship (Type. Print) Mae 20c. Location - City or Arthur 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1/6/2012 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) e of Funeral Service License 22. Name and Address of Facility March F/H East 1101 E. North Ave. 21. Signatu Baltimore, MID 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCVD. **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ed by the at 2 🗌 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be director, page 2 s performed? Yes 2 No 2 🗌 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 A Yes 2 □ No Hospital: 1 Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2≸ER/Outpatient 3 □ DOA မ funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural
2 Accident Injury 1 🗌 Yes 2 🗆 No after death. Director: A 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D06700 December 27 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sharon Bold 4940 Eastern Avenue, Baltimore, MD, 21224

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First\_Middle\_Last) 2. Date of Death Physician/ Dona1d Charles Rottman, III December 2011 8:53 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 212 Hawthorne Avenue Pikesville Baltimore Social Security Number . Age (In yrs. last birthday) If Under 24 Hrs Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours **Director** 212-04-6569 1 X M 2 🗆 F Yrs 44 Usual Residence of Deced July 19, 1967 Maryland 28a-f shov 10a. State 10h Count 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No Maryland Baltimore Pikesville 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 212 Hawthorne Avenue 21208 United States items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc. the Medical Examiner "natural", or þ 1 Never Married 2 Married ▼ Yes 2 □ No 1985 f Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: Completed White 199 Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Health Risk Manager IT Personnel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental It is marked or ၉ Donald C. Rottman, Jr. Elizabeth M. Hoch Department of Health and Important: If item 27 is n any injury or other traum. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Rottman/Brother 954 Hart Road, Crownsville, Maryland 21032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/04/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee George E 22. Name and Address of Facility MacNabb Funeral Home, P.A. MacNabb Seo 301 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee on each line. shock, or heart failure. List only one cause Immediate Cause (Final Glioblastoma Orset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? for Month Year Day 2 No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by hemipleala 1 Yes 2 WNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 No Yes 2 1 Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 V Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation the ☐ Accident☐ Suicide 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a Medical 👱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30,2011 December D0064099 MD and address of person who completed cause of death (Item 23a) (Type, Print) HOPKINS HOSBITAL 1550 OPLEANS STREET MARYCHNO SUITE IMIG 21231 State Registrar

DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2011 4:00am Remmers Edith December Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carrol1 Westminster Sun Valley Assisted Living 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year 1 □ M 2 🏋 F 93 216-01-2890 Director 1918 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 72 hours after death with the Maryland Director MD Carroll Westminster 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1951 Sams Creek Road 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 **X** No Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify Specify: white "natural", 3 X Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) domestic homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည William Edward Derreth Sr. Nellie Amanda Emich . Page 1 and 2 should tment of Health and M tant. If item 27 is mai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Remmers III (son) 1967 Sams Creek Rd., Westminster, MD 21157 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 1 - 6 - 12Sykesville. 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 Signature of Funeral Service License 400764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCLEROTIC
Due to (or as a consequence of): ⊈Nysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed After this certificate I 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 Anatural work 1 Yes 2 No 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 only one) 29d. Date signed (Month, Day, Year) e and title of certifie 29c. License number D0018 200 12130111 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) 700 A porle Md. Westamhoter CAITLA CHEDU AGANNA MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year IVERS 0725 M 4CE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton Prince George's 10211 White Avenue Social Security Numbe 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) 577-64-7156 **Director** 1 🗆 M 2 🗷 F 66 Yrs 06/29/1945 Washington, DC Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Clinton 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10211 White Avenue 20735 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11, Marital Status Armed Force Black, White, etc ģ 1 Never Married 2 X Married 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black 3 🗌 Widowed 4 🗌 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Civil Servant Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William B. Allen Vivian Josey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen R. Rivers/Husband 10211 White Avenue Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) cemetery, crematory or other place) Veteran's Cemetery 01/05/2012 MD Cheltenham, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ A disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Tause (Disease of injury that initiated events resulting in death) Last the attending physician and ched for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown cate has been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4  $\square$  Nursing Home 5  $\nearrow$  Residence 6  $\square$  Other (Specify) Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifier 29c. License number Date signed (Month, Day, Year) Necember 272011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Defense Huy ANNApolis Mo 21401

Registrar

State

VOI

MD

NTA

Registrar's Signature

Day, Year

3 2012

JAN 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 201 26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE OWSON anor If Under 1 Year | If Under 24 Hrs. Date of Birth (Mor)th, Day, 9. Birthplace (State or Foreign Country)
BALTI MORE M 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2□F Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evanting of the matthe 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21152 16809 by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 M If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental H-Important; If item 27 is marked oth any Injury or other traumatic event Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number or Town, State, Zip Code 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licensee MONKION MOZILLI Emberle -CHAPELY CREMATION SERVICES MODERA 23a. Parl 1. Enter the disease shock, or heart failure. Approximate Interval Between ns that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) P.O. ed by the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been si e 2 should b Completed Were autopsy findings available prior to completion of cause of 24a. Was an page performe After this certificate 1 ☐Yes 2 No 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes PON 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature/ nd title of certifie cause of death (Item 23a) (Type, Print) 30. Name/and Osler 101 101 32. Registrar's Signature 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:10 Physician/ December 28,2011 K. Russell Annamae Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Harford Joppa 318 Oakway Court 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 24, 1925 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 219-16-3933 Maryland 1 □ M **¾**□ F Director 86 Usual Residence of Deceden ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County death with the Maryland Director Harford Joppa 1 🗌 Yes 2 🂢 No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21085 USA 318 Oakway Court marked other than "natural", or items matic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 5:10 р.ш. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after white If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) State of Maryland Bookkeeper Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Kearney ည James Ignatius Keenan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Department of Health and Important: If item 27 is m any injury or other traum once. DECEMBER 28, 305 Chimmey Oak Drive-Joppa, Maryland 21085 Eileen Baldwin-daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other pla Gardens of Faith Cemetery 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Jan.2,2012 Rosedale, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 6-ME tadd -indrae 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CHRONIC OBSTRUCTIBE PULMONARY DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Samue tiethy list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ RUSSELL in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death signed by the at Id be detached for g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 X Unknown Division of Vital Records, ANNAMAE Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of cate has I autopsy performed' 1 🗌 Yes 2 🔲 No 1 Yes 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours aner common To the Funeral Director. After the Funeral Director, After the funeral part of the funeral common to the funeral common feet of the fe Certificate: injury 1 X Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Date signed (Month, Day, Year) 29b. Signature and title of certifie ath 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 ERNESTINE WRIGHT MD

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Louis William Reichart December 29,2011 4:38 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Gilchrist Hospice Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 216-20-6723 83 1 🗚 2 🗆 F March 07,1928 Parkville, MD. **Director** Usual Residence of Decede or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location the Maryland 10a. State 10d. Inside City Limits Director Baltimore County Glen Arm 1 Yes 2 No Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country' Funeral 21057 United States 4814 Long Green Road death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. White If Yes, Give Year or Dates. W.W. II 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) within 7 College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. Construction Superintendent Commercial Construction 12 N/A Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 pe Gertrude Patricia Thornton William Reichart permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Lois E. Edwards (Niece/Exe.) Baldwin, Maryland 21013 14103 Manor Road 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Location - City or Town, State (Harford County) Date Evans Fure al Charel and Cranation Services, Inc. Friday, Dec. 30, 2011 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Signature of Funeral Service License Seffrey L. Gair, Sr. OFS 22 Name and Address of Facility ives Funeral and Cremation Center, P.A.

Lic. #M00677 2325 York Read Timenium, Maryland 21093-2215 23a. Part 1. Enter the decase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ schemic disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the s should be detached b Hospital or Attending Physician: The law requires that the 24 hours after death.
Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No Division of Vital 25. Was case referred to medica director 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence P Other (Specify) NOSOL Q Hospital: 200 No ဂ္ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accide 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 only one ature and title of certifie 29d. Date signed (Month, Day, Year) 29b. Sign 29c. License numbe Techsor 29 2011

State Registrar 670

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32. Registra 's Signature

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TONSON MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHALLYES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 26, 2011 Leona E. Ricker 1:15 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Parkville Oak Crest Social Security Numbe 8. Date of Birth (Month, Day, Year) NOV 12, 1921 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 \( \text{M 2 \( \frac{1}{X} \) F 199-05-8419 90 Hours Maryland Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore Parkville MD 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 8800 Walther Blvd USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 1 Yes 2 No Specify: white 3 X Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Grocery Store Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Michalak Michal Chmielewski Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Nicholson-niece 16018 Hutchins Mill Road-Monkton, Maryland 21111 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Baltimore National Cemetery 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dec.30,2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Exams Funeral Chaptel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 21. Signature of Funeral Service Licensee L. ME Fudde 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between omplications Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Completed by Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant Box ( 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death
Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 2 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director; After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Accident injury 5 Pending work? 1 ☐ Yes 2 ☑ No Found, on flr in room z lac back of Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

AKINST, KENAISSINCE GARINS 4 Homicide determined Cakinst Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Graffying Number Practice of Tambers of my incoverage death occurred at the time date and place, and use to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CRUI MY 127/2011 and address of person who completed cause of death (Item 23a) (Type, Print) Michealle 8800 Walth Blud, Parkville, MO 21234 Hari (KUP 31. Date filed (Month, Day, Year) 32. Registrar's Signa State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2 Day 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year **Funeral** 7. Age (In vrs. last birthday) Month Day, Y Days 1 XM 2 - F Months Min. Country) Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Pikesv 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes Give Specify. Completed 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname <u>Kosentha</u> ည 19a. Informant's Name/Relationship (Type, Print) Bural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or 20a. Method of Disposition 20b. Place of Disposition (Name of Date UNK City or Town, State 20c. Location cemetery, cremator ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signatur Furnal Service Licenses 22. Name and Address of Eacility 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smock or heart failure. List only one cause on each line.

Immediate Cause (Final dise vie or condition resulting in death)

a. Due to (or see a cooccurrence) Approximate Interval Between set and Death SNITTE Physician Medical Due to (or as a consequing e of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exam Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of) 120 Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 2 0 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospita Other: 1 🗌 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Dursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No M Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 7.2011 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Balhin 31. Date filed (Month, Day, Year) 32. Registrar's Sanature State 3 2012 Registrar

DHMH 17 Rev 7/2009

Amend 25 per MD g923 1/24/12 amh Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 05: 24 PM Physician/ Day Roberto Reyes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL OF BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 87 **Director** 218-62-0673 1 **X** M 2 □ F Dec 15, 1924 Nicaragua ence of Decedent show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 5426 Lynview Ave 21215 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14, Race - American Indian 11. Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 □ No Specify: Specify: 3 🗌 Widowed 4 🗀 Divorced White Year or Dates Nicaragua 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Celedonio Reyes Aurora Urbina de Reyes . Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmen Reyes /Wife 5426 Lynview Ave Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Dec 28 4 Donation 5 Other (Specify) Beltsville, Maryland Chesapeake Crematory 2011 permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death e mode of dying, such as cardiac or respiratory arrest, Do not enter-Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Chysician Troxic ran disease or condition resulting in death) Medical Due to (or as a consequence of): 7 days. Examiner Sequentially list conditions, CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine cause. Enter Underlying • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical P.O. Box 68760 as the t 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Yes 2 L Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Division of Vital Records, 2 X No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of accordent. 24a. Was an autopsy performe Yes 27 death?

1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 X NO 2 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at Natural Accident injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

within 2

29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DECEMBER 23, 2011 MM

30. Name and address of person who completed cause of death (Item 23a) Type, Print) DENNIS moran NX

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State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 0 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Maria Rose  $A^{M}$ 2011 12:15 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Min (Month, Day, Year) **Director** 230**-**77**-**3761 1 □ M 2 🕇 F 83 09/20/1928 Italy Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 X Yes 2 No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 U.S.A. 4201 Westview Road within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ← No Specify. Specify: White Completed 3 → Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene.

ant: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Silvestro Pomes Teresa Papa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Westview Rd. Baltimore MD 21218 Jany Rose/ Niece 4201 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 01/02/2012 Mount Comfort Cemetery Alexandria, Virginia of Funeral Service Licenses 22. Name and Address of Facility 21204 Mi Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ GUARIAN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or injury that initiated events resulting in death) Last nding physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performe certificate 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Universing Home 5 Universidence 6 Other (Specify) Web 1 CA 2 No မ 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5  $\square$  Pending within 24 hours after death.

To the Funeral Director: A 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) December 30 2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NM Charles ST CHMMBS 6701 N AMON 31. Date filed (Month, Day, Year) 92. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1452 errine Robinson 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Baltimore University of Manyland Medical Ceviler If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. (Month, Day, Year) 216-84-6381 Director 1 □ M 2 👿 F 43 05/04/1968 Maryland Usual Residence of Deceden 28a-f shov 10a. State 10d. Inside City Limits aţ 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified N/A 1 XYes 2 No MD Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 2607 1/2 Garrison Blvd. 21216 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: Black 3 Widowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working within 72 Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) 10th Grade College (1-4 or 5+) N/AN/Aother traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) should be file and Mental F is marked or မှ Jesse Young Robinson Jeanette Ida Pointer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Amanda A. Johnson (daughter 2607 1/2 Garrison Blvd, Baltimore, MD 21216 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State on-site Crematory O 4 ☐ Donation 5 ☐ Other (Specify) Baltimore , MD 22 Name and Address of Facility 2140 N. Fülton gn ture of Funeral Societ Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Multi-Drug Resistant Klassella preumoniae disease or condition resulting in death) Medical Due to (or as a consequenc-**Examiner** andidemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events endocarditis attending physician and I for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy bage, performed? certificate 1 Yes 2 No Yes 2 No Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes \_2 🗌 No မ ER/Outpatient 3 DOA 1 Inpatient 2 🗆 this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending e Funeral Director: At bletely filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 🛮 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2, To the F complet only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1093014524 )ec 20/1 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

ollean

31. Date filed (Month, Day, Year)

Greene

32. Registr

Baltimore.

MI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3 Pay Louis A. Schrieber Dec. 201°7 Medical County of Death
Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death
Middle River **Examiner** 36 Tea Rose Drive 5. Social Security Number 214-38-5823 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Months NOV/ 24/1942 69 1 🛂M 2 □ F **Director** Usual Residence of Decedent 28a-f show 10c. City, Town or Location Middle River 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Baltimore MD 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 21220 10g. Citizen of What Country? Funeral 36 Tea Rose Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 K Yes 2 No White If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify "natural", 3 Widowed 4 Divorced Completed injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than. ife. DO NOT use retired)
Meat Cutter Elementary/Secondary (0-12) College (1-4 or 5+) Esskay 9th marked other Be 18. Mother's Name (First, Middle, Maiden Surname)
Theresa Gollar 17. Father's Name (First, Middle, Last) aryland Ith and Mental H ပ Robert Schrieber K permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number, or Rural Route Number, City or Town, State Zip 2021220 Marilyn Schrieber/Wife このよ Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State
Baltimore MD 20b. Place of Disposition (Name of 1 월 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly "Hill of Cemetery 1/3/12 4 Donation 5 Other (Specify) 21. Signatus f Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. D Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an nis certificate has I autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 0 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral E

completely filled Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of person who completed cause of death (Item 23a) (Type, Print) filed (Month, Day, Year) JAN 0 3 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Per DVR G923 1/03/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30°M Physician/ Tackha Medical or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number **Examiner** 3Altimor -8 Jecours N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 🔀 M 2 🗆 F Davs Min. Months Hours 212-60-8483 MD Director 59 12/1952 Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location within 72 hours after death with the Maryland Director MD N/A 1 ¥ Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4017 Liberty Heights Ave 21297 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Examiner was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black "natural", 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Various Jobs 11th N/A Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Jessie Stackhouse Gertrude McCallum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Crowder-Sister Palmcoast, FL 32137 Andrews Ct. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State King Memorial PK. 12/29/201 permit. Page Department of Important: If any injury or MD Randallstown, 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ H disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate Examine if any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? Yes 2 No has death?
1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Certificate: To Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1 Tes 2 No 1 Anpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funeral pirector is a funeral completed filled in by the funeral completed filled in the funeral completed filled 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1all 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21228 Catonsville,MD 413 Commomwealth AVE. Willie Bota Mvemba

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Dameone Suggs	State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death  Page No. 2   1   2   1						
Physician/	1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death						
Medical Examine	December 21, 2011						
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  University Shock Trauma  4c. County of Death  Baltimore						
Funeral	University Shock Trauma  Baltimore  N/A  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 24Hrs.   8. Date of Birth(MM/DD/YYYY)   9. Birthplace (State or						
Director	215-86-6055 1 Months Days Hours Min. 8/16/1971 Foreign MD						
any	Usual Residence of Decedent  10a. State						
<b>*</b> .	MD Baltimore Edgewood 1 □ yes 2 🔯 No.						
the Maryland a or 28a-f sh tiffed at once	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?						
ith the Maryland 23a or 28a-f sho notified at once							
or items 23 must be no	11. Marital Status 1						
5-0036 led within 72 hours after death with the Maryland stygene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once Completed by Funeral Director	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Black						
ours aft	Tor Dates:						
5-0036 led within 72 hours after Etygene. other than "natural", the Medical Examiner Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) Chemist Pharmaceutics  12th N/A Chemist International						
within within ber the Medi	12th N/A Chemist International  17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)						
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	17. Father's Name (First, Middle, Last)  Gerald W. Suggs  18. Mother's Name (First, Middle, Maiden Surname)  Deborah E. Thomas						
ID 2121 should be fi and Mental J 77 is marked natic event,	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
E B B G ≤	Nichole Suggs - Wife 1857 Simons St. Edgewood, MD 21040  20a. Method of Disposition   20b. Place of Disposition (Name of cemetery   Date   20c. Location - City or Town, State						
Baltimore, permit. Pages I as Department of Hei Important: If ite	1 Mayorian 2 Compation 3 Remarks from State Crematory or other place)						
Baltimo permit. Page Department of Important: injury or oth	4 Donation 5 Other Specify:						
Balti permit. Departm Imports	21. Signature of Funeral Service Licens 22. Name and Address of Facility March F/H East 1101 E.  North Ave. Baltimore, MD 21202						
Physician	23a. Part Denter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and						
/ /Medical Examiner	Immediate Cause (Final disease a. Gunshot Wounds (2) of Head Death						
·	or condition resulting in death)  Due to (or as a consequence of):						
Jer Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
ed nsit <b>Examiner</b>	cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):						
executed an and al - transit	d.						
O,  e be executed  ysician and burial - transit  edical Ex	UNPENDED AMENDED						
68760 certificate of nding physise as the bh	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year						
b. Box 6876( the death certificate oy the attending physched for use as the b Physician/Me	past 12 months?  4 Pregnant at time of death 5 Other (Specify)						
Bo te deat the at red for	1 Yes 2 No 9 Unknown g Unknown						
Records, P.O. Box The law requires that the death cate has been signed by the arte page 2 should be detached for u Completed by Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown						
Records, The law require: ficate has been sig. page 2 should be Completed	24a. Was an 24b. Were autopsy findings available						
of Vital Records, og Physician: The law requirement of the this certificate has been someral director, page 2 should In: To Be Completed	autopsy prior to completion of cause of performed? death?						
	25. Was case referred to medical 26.Place of Death (Check only one)						
f Vital   Physician: er this certification of To Be (	examiner?  1 Yes 2 No    Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other   Nursing Home 5   Residence 6   Other:						
n of Vital ding Physician: 3. There this certificated, funeral director, on: To Be (	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred						
Sion Attend r death. ector: by the f	2 Accident Investigation Dec 21, 2011 2227 hrs						
Division o spital or Attending nours after death. nearal Director: Aft filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify) Local Street						
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the 1 ledical Certificatic	29a. Certifier						
To the Hos within 24 h To the Fur completely ledical	(Check only 2 Certifying Physiciant: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
To wif	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)						
	Caral Hallan O.C.M.E. December 22, 2011						
5	30. Name and address of person who completed cause of death (Item 23a)						
J	Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  31. Date filed (Month, Day, Year) 32. Registrar's Signature						
State Registrar	31. Date filed (Month, Day, Year)  JAN 0 3 2012  32. Jegistrar's Signature  A. January						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 4:35  $A^M$ 10 10 Eddie Lee Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 806 N. Brice Street 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Age (In vrs. last birthday. Country) Days Hours Min 1 X M 2 - F S.C. 69Yrs **Director** 250-72-2562 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f sho idical Examiner must be notified at Director N/A 1 Yes 2 No MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral USA 21217 806 N. Brice Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
Fant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner munor or other traumatic event, the Medical Examiner munor or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No
If Yes, Give 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify. Baltimore, Maryland 21215-0036 Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Linen of the Week N/ALaborer 17<del>-</del>h Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Marie Smith Eddie Curry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2110 Mayslanding Rd. Lot 189 Millville, NJ 08332 Department of Health Important: If item 27 any injury or other th Larry Evans-Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 10/31/2011 Salem Co., 4 ☐ Donation 5 ☐ Other (Specify) Fortmott cemetery March F/H East 1101 E. MD 21202 North 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ) cm Baltimore, Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. i. ian/ METASTATIC Colon disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner くいしょうし Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last HUBURH Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death?
1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 💢 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident To the Hospital or Attending within 24 hours after death.

To the Funeral Director; Afte completed filled in by the fun 5 Pending Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe BILL D5020 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) onkot GARROR ST. N. Baltmone 7 10

State

Registrar

31. Date filed (Month, Day,

JAN O

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0920 @ 2011 12 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore A lemoria HUSPITA Social Security Number . Age (In yrs. last birthday If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 219-56-5180 Usual Residence of Decedent **Director** 1 XM 2 □ F 28a-f show 10a. State 10b Count 10c. City, Town or Location 10d. Inside City Limits must be notified at Completed by Funeral Director 1 X Yes 2 No tomore or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21206 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. per rit. Page 1 and 2 should be filed within 72 hours after dea Decartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Armed Forces?
1 X Yes 2 ☐ No If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ebec 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 2012 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H East 23a. Part 11/2 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myo Carai disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to or as a consquence of attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 as the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Cther (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy perform certificate Hospital or Attending Physician: the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending Division within 24 hours after death. To the Funeral Director: A ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) AT 2438946 12/31/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 East University Parkway, Baltimore MD 21218 PAID SHAKIR 31. Date filed (Month, Day, Year) State JAN 0 Registrar

DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

s St. Amant		1- For State Certificate		Reg.	No. 201			
Physician cal Examin	ш.	1. Decedent's Name (First, Middle,Last)  James E. St	. Amant Jr.	Date of Death     Month December 2	ay Year 4, 2011	3. Time of Death 1119 hrs		
		4a. Facility Name (if not institution, give street and number) 5427 Belle Vista Avenue	4b. City, Town, or Location of Baltimore		4c. County of Death	_		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 219-94-0145 1X M 2 F 41	yrs. If Under 1 Year If Under 1 Year Year If Under 1 Year If U		MM/DD/YYYY) 9. Birt Foreig 0 70 Cou			
w any	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Li				10d. Inside City Limits 1 X Yes 2 No		
th the Maryland 23a or 28a-f show notified at once	Director	MD NA Balti  10e. Street and Number  5427 BelleVista Ave	10f. Zip Code 21206		Citizen of What Cour			
eath with the items 23a ust be notif	L		Was Decedent of Hispanic Original Mexican, Mexican, Mexican,	gin? ( Specify Yes or No-	14. Rece - Ameri White, etc.	can Indian, Black,		
s afte	<u>a</u>	3 Widowed 4 Divorced of Parks:  15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Education (Specify only highest grade completed)	Yes 2 No specify: edent's Usual Occupation (Give ing most of working life. DO NOT	kind of work done	Specify: Bla	ndustry		
led within 72   Hygiene. other than " the Medical I	Completed	Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) 3yrs  17. Father's Name (First, Middle, Lest)	Dispatcher	's Name (First, Middle, Mai	Public Wo	orks 1		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica		James E. St. Amant Sr.		da Watts Be	ennett	Zin Codo)		
ages 1 and 2 should be fi nt of Health and Mental 1 it: If item 27 is marked other tranmatic event,	1	Freda Bennett-Mother 542	27 Bell Vista	a Ave, Bali	cimore, 1	Md 21206		
		1 Burial 22 Cremation 3 Removal from State 4 Donation 5 Other Specify:	or other place) -Site	12/29/201	*			
		Juga Hert	Tarch Myhor Weigh 1300 Wabash A	Ave, Baltin	nore, Md	21215		
nysician Medical kaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease e. Hypertensive Cardiovascular Disease Death						
	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
d ansit	Exall	Course Finter Underlying Course (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):						
e be exect sician an burial - tr		UNPENDED AMENDED						
ath certificate attending phy for use as the l	FEMALE:   23c. If yes, outcome of pregnancy   23d. Date of de Month   2   Fetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (Specify)   9   Unknown   2   Other (Specify)   9   Unknown   9   Other (Specify)   9							
signed by the								
he law require tte has been sig age 2 should b	Completed			24a. Was an autopsy performe	24b. Were au prior to death?	topsy findings availab completion of cause of		
ician: The s certificate rector, page	g n	25. Was case referred to medical examiner?    Hospital: 1   Inpatient 2   ER/Outpat	26.Place of Death					
Attending Phy death. ector: After thi by the funeral d	tion: 10	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time		? 28d. Describe how		. Scene		
pital or Atten ours after death teral Director: filled in by the	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, (Specify)	c. 28f. Location (Stre or Town, Stat	(Street and Number or Rural Route Number, Cit State)				
To the Hospital or A within 24 hours after To the Runeral Dire completely filled in b	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
E S E S		29b. Signature and title of certifier	29c. License number O.C.M.E.		9d. Date signed <i>(Mo.</i> December 29, 20			
3			00 W. Baltimore Street,	Baltimore, MD 2122	23			
Sta Registr	~	31. Date filed (Month, Day, Year)  JAN 0 3 2012  32. Registrar's Signature	,					
T/ Rev 1/200	T	ORIGI	NAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:30 A<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 2583 Colebrook Drive Prince George's Temple Hills If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Min 578-42-5749 **Director** 1 □ M 2 🗶 F Aug 10, 1916 95 Alabama Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits notified at Director 1 Yes 2 X No Maryland Temple Hills Prince George's 10e, Street and Number r items 23a or ner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral United States 2583 Colebrook Drive 20748 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Medical Examiner Armed Force Black, White, etc. þ "natural", or 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 African If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 Divorced Completed American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked or marked မ other traumatic Tom Shealey Mattie Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If item 27 is, any injury or other traumonce. Marvin Verter / Nephew 14608 April St. Accokeek, MD 20607 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 12/31/2011 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, M MD 21029 23a. Part 1. Enter the sease, or complications that caused the shock, or heart failure. List only one cause in occil line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 98 that initiated events resulting in death) Last Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year signed by the at 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate | 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After 1 the Hospital or Attending Natural 5 Pending injury work? 2 🗆 No filled in by the Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and ti 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

68760

Box (

P.O.

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31, Date filed (Month, Day, Year) . - - .

Tinisha Cheatham 5100 Auth Way Suitland, MD 20746

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:25 AM ZO I DECEMBER Ricardo Segura Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** partimere If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 ፟ M 2 ☐ F 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Pay, Months Days Hours Min. Philippines 220-19-7011 1932 **Director** 79 Usual Residence of Decedent f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 🗆 Yes 2 😾 No MD Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 5502 Oakland Road 21227 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 XXM arried Baltimore, Maryland 21215-0036 Specify Filippino 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Omni Hotel Maintenance Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ricardo Segura Sr. Arsenia Manalaysay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5502 Oakland Road Arbutus Maryland 21227 Emma Segura-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Atlantic Crematory Glen Burnie Maryland 4 ☐ Donation 5 ☐ Other (Specify) Dec.31,2011 ral Service Licens 22. Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring ROad Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ABBHYTHMIA Immediate Cause (Final Onset and Death VENTAICULAR Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): CARDIO MYO PATITY Examiner YEAKS NOHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated second Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MYOCARDIAL INPARCTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Vital Records, Completed COAD 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No certificate has performed Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No 힏 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours at er death To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MEDICAL RESIDENT MICEMBER VY

Registrar
DHMH 17 Rev 7/2009

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MITIMORE

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

32 Registrar's Signature

31. Date filed (Month, Day, Year)

**JAN 0 3** 

11-09826 Rita

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Rita A. Stone	1- For State Registrar	te of Maryland / Depar <i>Cert</i>	tment of Health and Mi ificate of Death		eg. No. 201	1 4212		
Physician/ Medical Examine	1. Decedent's Name (First, Middle,			2. Date of Deat Month December		3. Time of Death 1630 hrs		
	4a. Facility Name (if not institution,		4b. City, Town, or Locat Bethesda		4c. County of Death Montgomery			
Funeral	Suburban Hospital  5. Social Security Number  6	5. Sex 7. Age (In yrs. las		Under 24Hrs. 8. Date of Bird	th(MM/DD/YYYY) 9. Birth			
Director		1☐M 2⊠F 62	Yrs. Months Days H	lours Min. December	r 27,1949 Foreign	ntry) Virginia		
ум апу	Usual Residence of Decedent  10a. State 10b. County		Fown or Location Potomac			10d. Inside City Limits  1 Yes 2 X No		
the Maryland a or 28a-f sh tifted at once Director	Maryland Montgo 10e. Street and Number 12305 Captain S		10f. Zip Code 20854		Og. Citizen of What Coun United State	-		
Baltimore, MD 21215-0036  pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		12. Was Decedent Ever in U.S Armed Forces?	5. 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	: Origin? ( Specify Yes or No kican, Puerto Rican, etc.)	- 14. Race - Americ White, etc.	an Indian, Black,		
s after de iral", or i niner mu	3 Vidowed 4 Divol	1 Yes 2 No	1 Yes 2 No spe		Specify: Whi			
5-0036 ed within 72 hours tygiene. other than "natur the Medical Exan	15. Decedent's Education (Speci Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working life. DO	NOT use retired)	Public Pol			
-003( I within giene. ther that	17. Father's Name (First, Middle, L	ast)	Survey Researche	e T Other's Name (First, Middle, N	Research Maiden Surname)			
be filed and Hydra of Cent, the	Hermon Stone		· · · · · · · · · · · · · · · · · · ·	Genevieve V.				
MD 21215-0036 42 should be filed within 7 th and Mental Hygiene. a 27 is marked other than umartic event, the Medical	19a. Informant's Name/Relationsh Thomas A. Harpe		19b. Mailing Address (Street and 12305 Captain S	Smith Court, I	Potomac, Mar	yland 20854		
Ore, Nges I and to of Health: If item	20a. Method of Disposition  1 Burial 2 X Cremation	3 Removal from State Mon	lace of Disposition (Name of cemeter rematory or other place) tgomery matorium, Inc.	January 3,	Bethesda,			
Baltimore, cemit. Pages I an Department of He important: If ite	4 Donation 5 Other Spe 21. Signature of Funeral Service L		22 Name and Address of Fa	acility Robert A.	Pumphrey Fu	neral Home/		
면 원칙목표 Physician			Rockville, In Rockville, Ma	as cardiac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and		
/Medical Examiner	failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	a. Cirrhosis of the Liver  Due to (or as a consequence of)	):			Death		
0	Sequentially list conditions,	b						
ted Insit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence of	):					
o, be executed burial - transit	UNPENDED	d						
68760, certificate be nding physic se as the buritary Median		23c. If yes, outcome of pregn		ctopic pregnancy	23d. Date of delivery Month D	eay Year		
b. Box 6876( the death certificate by the attending phy ched for use as the b	1 Yes 2 No 9 Unkr	nown 9 Unknown	ath 5 Other (Specify)					
i, P.O. I	Hypertension, Corona		sulting in the underlying cause given egurgitation, Hypothyroidism		obacco use contribute to			
Records, The law requires ficate has been signage 2 should be	Breast Cancer			24a. Was	psy prior to c	topsy findings available ompletion of cause of		
tal Reco	3		00 80000	1 <b>✓</b> Yes	ormed? death? 2 No 1 ✓ Ye	es 2 No		
Vital Rechysician: The this certificate I director, page		Hospital: 1 ✓ Inpatient 2	ER/Outpatient 3 DOA Othe	Peath (Check only one)  Practice   Nursing Home   5	Residence 6 Other			
on of Nading Ph.	27. Manner of Death	28a, Date of Injury (Month, Day,Year) ing	28b. Time of Injury 28c. Injury at 1 Yes		how injury occurred			
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 broth started earth. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitival Certification: TO Be Completed by Directoral Medical Expedical Control of the contr	2 Accident Inves 3 Suicide 6 Could determ	tigation 28e. Place of Injury - At homined (Specify)	ome, farm, street, factory, office building	ng, etc. 28f. Location ( or Town, S	(Street and Number or Ru State)	ral Route Number, City		
Di To the Hospital within 24 hours a To the Funeral I completely filled	4 Homicide  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)  2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							
To vitil	and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Mc)  O.C.M.E.  December 31, 2							
	30. Name and address of person Victor Weedn MD JD	who completed cause of death (Item Assistant Medical Examir		et, Baltimore, MD 212	23			
Stat	e 31. Date filed (Month, Day, Year)	32 Registrar's Signatu						
Registra  DHMH 17 Rev 1/200		2 June A. A	ORIGINAL					
Pt Drivin 17 Rev 1/200	,	WITTE	ORIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 42123 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12 Month Johnny Caswell Senior 23<sup>y</sup> 20<sup>1</sup>1 5:45A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A Baltimore 3810 Rokeby Rd. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1**x** M 2 □ F Months Days Hours 12/08/1947 **Director** 64 Yrs 215-46-7618 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director notified MD N/A ty Yes 2 No **Baltimore** 10e, Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be Funeral 23a 3810 Rokeby Rd. 21229 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō Completed by 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or 1 Yes 2 XNo Specify. Specify: Black 3 Widowed 4 Divorced th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Food Director Catholic Charities Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Johnnie Hatchett Ivory Cuffie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Senior(son) 1201 Wildwood Pkwy, Baltimore, MD 21229 other I 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 remation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Department o Important: If any injury or 9 on-site Crematory 12/27/11 Baltimore, MD Signature of Funeral Service Licensee Joseph Addres of Bridwn J. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 line 201/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition 201 Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or iinjury Due to (or as a consequence of): Examir burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician use as the burial Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Day Month Year Pregnant at time of death 5 Other (specify) signed by the a d be detached fi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 💆 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law page 2 : After this certificate has autopsy performed' 1 Yes 2 No Yes 2 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2.X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident death. Investigation 24 hours after deat Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the ! only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 22 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar ~ 1S

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32. Registrar's Signature

MDSB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

9. Birthplace (State or Foreign

States

10d, Inside City Limits

1 🗆 Yes 2 😾 No

Maryland

White

1123AM

Year

Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLIN Square DR Balto md 21237 4000 ORIGINAL

State Registrar

DHMH 17 Rev 06-2011

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Shinners

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Day 9:45 P M SSICA 2011 OLSON 2 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** 4b, City, Town, or Location of Death Howard Mandrin Hospice House Hardwood Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex **Funeral** Hours **Director** 1 🗆 M 2 💢 F 577-58-1686 08/30/1942 Washington, DC 69 Usual Residence of Deced 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f MD Prince George's Upper Marlboro 1 X Yes 2 No 10e. Street and Numbe P 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 10137 Prince Place apt. #202 USA 20774 items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 👿 No Specify Specify: Black 3 Widowed 4 □ Divorced "natural", Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Cosmetologist Private Be 17. Father's Name (First, Middle, Last) of Health and Mental H if item 27 is marked ot r other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) မ Lila Meek John Glen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health a t: If item 27 is or other trai 10137 Prince Pl., apt.#202 Upper Marlboro, MD 20774 Robyn Tolson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 12/30/2011 Suitland, MD Lincoln Memorial . Signatur of Funeral Service Lice 22. Name and Address of Facility Marshall-March Funeral Home nau 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? be detached for Day Year Pregnant at time of death 1 Yes 2 g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Sther (Specify) MANDICIN မ 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred HOSPKE Certificate: or Attending 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Gertifying Nurse Fractificnen To the best of my knowle 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fense Huy ANNAPAlis MD 21401

Registrar DHMH 17 Rev 06-2011

State

Marian A. Parrott

31. Date filed (Month, Day, Year,

445

12. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:40 PM December 2011 NILA PAMELA TAYLOR Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Days 578-72-4391 Director 1 □ M 2🗓 F June 21, 1957 Pennsylvania 54 28a-f show death with the Maryland at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director notified Prince George's Laurel 1 🔀 Yes 2 🗌 No MD 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral USA 13505 Avebury Drive, Apt. 31 20708 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō b 1 Never Married 2 X Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: Black "natural", 3 Widowed 4 Divorced Completed Hygiene. other than "natura ent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Retail 12th Entrepreneur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic ever ည e 1 and 2 should be of Health and Ments Dolores Hill Frank Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 13505 Avebury Drive, Apt. 31, Laurel, MD 20708 Michael Antonio Taylor/Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 12/29/2011 Odenton, MD 4 Donation 5 Other (Specify) West Arundel Crem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, M01103 313 Talbott Avenue, Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph. i i Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Septic Shock Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Pneumonia and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 🔀 No 1 ☐ Yes 2 L 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Acute Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛛 Unknown 24b. Were autopsy findings available prior to completion of cause of COPD, Diabetes, Morbid Obesity 24a. Was an After this certificate has autopsy perform death? 1 ∐ Yes 2 🔯 No Yes 2 V No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 X No Certificate: To 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No eral Director: A filled in by the fu Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) To the Hospital or within 24 hours aff To the Funeral Di Medical 29a. Certifier 💒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifier 29d. Date signed (Month, Day, Year) D68096 MD December 25, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Satyam Ashvinkumar Shah, 1500 Forest Glen Road, Silver Spring, MD 20910 32. Regist ar's Signature State Registrar

Please Type of Printin Black Indelible Ink. Ensure All Copies Are Legible. 25 per ME 9923 1/24/12 amh
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 6 9 P M Month Physician/ 5. Year Mar Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b N/A UMM If Under 24 Hrs. Date of Div. (Month, Day, Year 1940) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex If Under 1 Year 8. Date of Birth **Funeral** Months Days Hours Min Scot land 1 □ M 2/1/2 F 220-58-1624 71 Yrs Director May Usual Residence of Decedent 28a-f shov 10b. County at 10a. State Ô 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21210 West Ave items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 0 þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Own Home UNKNOWN Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F 7 is marked of ၉ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Allan Taylor 1215 W. Lake Avenue, Baltimore, MD 21210 permit. Page 1 and 2 sł Department of Health a Important: If item 27 is any injury or other tra Husband 20a. Method of Dispasition

1 → Burial 2 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Memorial Date 20c. Location - City or Town, State 12/30/2011 Timonium, Maryland Name and Address of Facility Burgee Henss-Seitz Funeral Home, Inc,. 3631 Falls Road, Baltimore, Maryland 21. Signature ineral Service Lic 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Inter al Between O e nd Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** CERTIFICATION MPROVED BY WEDICA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed attending physician and for use as the buriaf-tran Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No 9 Unknown P.O. signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 1 ER/Outpatient 3 ☐ DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) After this s after death.

I Director: After this d in by the funeral d 28a. Date of injury (Month, Day, 27. Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 CH 24 2 👿 No Investigation 6 Could not be 28f. Location (Street and Number or Bural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours aft

To the Funeral Di

completed filled in one Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d. Date signed (Month,, Day, Year) 2030868 on who completed cause of death (Item 23a) (Type, Print) 202 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 29,2011 Samuel Melvin Tagg December 3:37 A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Baltimore County Towson Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Mir 216-03-8338 93 Director 1**X** M 2 □ F July 06, 1918 Towson, Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f show any injury or rother traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County 1 Yes 2X No Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12607 Manor Road 21057 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Specify 3 🛚 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Alban Tractor 11 N/A Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Samuel Tagg Alma M. Warfel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sharon M. Beaumont (Dau.) 12535 Manor Road Glen Arm, Maryland 21057 20a. Method of Disposition 20b. Place of Disposition (Name of Location - City or Town, State Satürday cemetery, crematory or other place) (Baltimore County) 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Dec. 31, 11 Baltimore, Maryland Moreland Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) rescentification of the Parties of Timenium, Maryland 21093-2215 of Funeral Service Signat PM 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. Ust only one cause on set line. Approximate Interval Between Onset and Death Immediate Cause (Final ebilit Pnysician/ disease or condition resulting in death) Medical Due to or as a consequence of Examiner don Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to or as a consequence of physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day been signed by the a should be detached ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available 24a. Was an cate has l autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Tes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the I

comple only one 29c. License number 29b. Signatur 303 8 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MJ om son HARIES 620 works 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give st 4b. City, Town, or Location of Deat Examiner Mony COMa If Unde If Under 8. Date of Birth Birthplace (State or Foreign st birthday) **Funeral** (Month, Day, Year) b 12 1942 Florida Months Hours Min. 1 X M 2 □ F 69 Yrs Director 262-64-0528 Usual Residence of Deceden 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Examiner must be notified at Director 1 ☐ Yes 2 🔀 No MD Prince George's Mitchellville 10f. Zip Code 10g, Citizen of What Country? 9 10e, Street and Number 23a Funeral United States 20721 4025 Caribon St. items death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 7 Yes 2 No
If Yes, Give Black, White, etc. 5 þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 1967-71 Black "natural", 3 Widowed 4X Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 4 Government Contractor Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (Unknown) Edna Townsend Auburn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 shument of Health at tant: If item 27 is 30126 4899 Nesta Ct., Mableton, GA Brian Townsend / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Chesapeake Crematory 12/31/2011 Beltsville, MD . Signature of Funeral Ser Rapp Funeral and Cremation Services Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20910 Gist Ave., Silver Spring, MD Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam burial-transit and quence of): resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: f yes, outcome of pregnancy
Live Birth 2 - Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Dav Pregnant at time of death the detached 9 Unknown Division of Vital Records, P.O. signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably Completed page 2 should been Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate has death? 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: Nwithin 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2. No ER/Outpatient\_3 DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No M Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Cartifyina Nursa Practioner: To t sest of riny knowledge, death. 29b. Sign and title of certi 29c. License number 30. Name a State 201 3 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death County of Death Westminster If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 064-18-2454 Director Usual Residence of Decedent show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll New Windsor 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 2613 Garstlynn Court 21776 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No WWII Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white "natural", 3 X Widowed 4 ☐ Divorced Year or Dates or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) **HPS** driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gaetano Vitaglione Amelia (maiden name unknown) and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Nancy Nardi (daughter) item 27 2613 Garstlynn Ct., New Windsor, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H
Important: If ite
any injury or ot Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Springfield Cemetery ! 4 ☐ Donation 5 ☐ Other (Specify) 12-31-11 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel ge Harght Par .0. Box 195 Sykesville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CONSESTIVE HEART FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner LUART DISEASE ISCHEMIC Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed' 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပု 1-Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending Accident 1 Yes 2 No after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined า 24 hours ส e Funeral โ 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D30263 12-28-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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200 MEMORIAL AVENUE WESTMINSTERMD 2115

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:25A Physician/ Alexandra J. Witt DECEMBER 28, 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death BALTIMORE SAINT JOSEPH MEDICAL CENTER TOWSON **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 186-32-7481 **Director** 72 1 M 2 X F Oct.16,1939 PA Usual Residence of Decedent or 28a-f show notified at within 72 hours after death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Essex 1 Yes 2 No ö 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Examiner must be 23a Funeral 21221 USA 221 Virginia Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or þ 1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White "natural" Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Mediconce. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) own home Homemaker <u>12th</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Stetchko Louis Kuhar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Melany Wilson/daughter 10329 Bird River Road Baltimore MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State St. Joseph Church Cemetery 12/31/11 Fullerton MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Liden 22. Name and Address of Facility 300 Mace Ave. Balto. MD alud Day Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or comp cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph\_sician/ RESPIRATORY FAILURE disease or condition resulting in death) Medical ADULT RESPIRATORY DISTRESS SYNDROME Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) METASTATIC BREAST CANCER Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical ENDOCARDITIS Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 LI Fetal dea Live Birth 2 - Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Day signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL INSUFFICIENCY 1 Yes 2 No 3 Probably 4 Unknown Completed peen DIABETES 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy s certificate has director, page 2 performe death? 1 ☐ Yes 2 🕱 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 💢 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 5 Pending Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 24 hours after de e Funeral Directo letely filled in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check the only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MO 29c. License numbe 29d. Date signed (Month, Day, Year) D31826 12-27-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD LINTHICUM, M.D. 7601 OSLER DRIVE TOWSON, MD 21204 31. Date filed (Month, Day, Year) State 2. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

JAN O

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1 Month 8:47 A M 20 Day 20<sup>Yea</sup>1 Physician/ Beulah Wright Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Manor Care Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 1 □ M 2 🛣 F Months (Month, Day, Year) VA 231-26-8182 88 Director Usual Residence of Decedent 10b. County N/A 10c. City, Town or Location Baltimore 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f shov Examiner must be notified at death with the Maryland **Funeral Director** MD 1 X Yes 2 No 10f. Zip Code 21237 10g. Citizen of What Country? 10e, Street and Number USA 8873 Fontana Ln. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 72 hours after Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give Year or Dates "natural", 3 X Widowed 4 □ Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Provident Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) N/A Personal Care Nursing Be 18. Mother's Name (First, Middle, Maiden Surname) Anna Stokes 17. Father's Name (First, Middle, Last) should be file and Mental F is marked o permit. Page 1 and 2 should be .
Department of Health and Mental Important: If item 27 is meany injury or other. Willie Stokes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) Terrance Marshall-Daughter 8873 Fontana Ln. Baltimore, MD 21237 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

. Zion 1 A Burial 2 Cremation 3 Removal from State 12/27/201 Lansdown, MD Mt. 4 Donation 5 Other (Specify) 22. Name and Address of Facility March F/H East 1101 E. North 21. Signature of Funeral Service Linensee Drum - Milan Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death demention Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Kidner 1 Tes 2 No 3 Probably 4 Thinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 We 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 20 201) M.D D 69540 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Swite 204 Parkville MD 21239 12d Shah SM3 Walkam Jigar. 31. Date filed (Month; Day, Year) State 2012

Registrar

JAN O

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:08 PM liams 23 12 2011 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4c. County of Death Memoria Union Baltimore NA Hospital If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** 213-68-7617 Director 1 🗷 M 2 🗆 F 8-1958 MD Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho her must be notified at Director 1 X Yes 2 No timore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 USA ana 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian other traumatic event, the Medical Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 🗌 Yes 2 💢 No id Mental Hygiene. marked other than "natural", Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) me College Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) if Health and Mental 2 Johnson Wa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Williams 6128 Alameda Baltimore rinnia 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 s Department of h Important: If ite 1 Durial 2 X Cremation 3 Removal from State ò Baltimore 28/2011 4 Donation 5 Other (Specify) emetery Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 1101 E. North Ave Baltimore MO 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arrhythmia Physician/ 5 days lerminal disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Hypoxic Brain Injur 5 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Year 1 Yes 2 9 Unknown Records, P.O. signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has certificate ha perform death? 2 🗌 No 2 🔀 No 1 Yes Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's 2 🗙 No Hospital 1 Yes ပ 1 No Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 🛮 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD At 2438946 12, 23, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) The Wang East University parkway Baltimore MO 21218 20 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 17 per fh g923 1-6-12 vt State of Maryland / Department of Health and Mental Hygiene 20 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 31 2011 6.208 Rufus Mike Williams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDE CLEN BURNIE BALTIMORE WASHINGTON MEDILAL C ENTER 9. Birthplace (State or Foreign 8. Date of Birth Age (in vrs. last birthday If Under **Funeral** (Month, Day Yea Sept. 26, Months <sup>(ar)</sup>1927 Virginia 84 Director 231-26-7614 Usual Residence of Decedent 28a-f show 10d, Inside City Limits 10a, State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Severna Park Anne Arundel Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 0 23a Funeral USA 21146 640 Severn Road items 2 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married Yes "natural", or ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates SpecifWhite Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Me. Elementary/Seconday (0-12) College (1-4 or 5+) C&O Railroad Railroad Inspector 8 Be 17. Father's Name (First, Middle, Last)

Jasper R.

Rudolph J. Willi 18. Mother's Name (First, Middle, Maiden Surname) မ Lela Baker Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 640 Severn Road Severna Park, MD 21146 Bruce Williams Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition cemetery, crematory or other place Jan 02 1 X Burial 2 Cremation 3 Removal from State Whitakers, NC 4 Donation 5 Other (Specify) 2012 Whitakers Cemetery 22. Name and Address of Facility
Stallings Funeral Home, P.A. Service Lice 21. Sign 3111 Mountain Road Pasadena Maryland 21122201 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, suse on each line. ations 23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HEUMOHUA disease or condition Medical resulting in death) PEBPONASCULAR ARCIDENT Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and resulting in death) Last Due to (or as a consequence of): physician a sthe burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) the g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 Yes 2 No has death?
1 Yes 2 No eral Director: After this certificate I filled in by the funeral director, page Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: To the Hospital or Attending 5 Pending after death. Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) December 31 2011 D 45149 MO of Hospital Drive Glen Burne Ms 20161 30. Name and address of person who complete 301 6V 31. Date filed (Month, Day, Ye 32. Registrar' Signature State JAN 0 3 2012 Registrar

SILLIAMS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time o. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Worlland Wenter enter Irene Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner sieneral timore Year If Under 24 Hrs. Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under **Funeral** 219-18-9836 87 **Director** 1 □ M 2 💢 F -2-24 MD Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shor Examiner must be notified at Director 1 X Yes 2 No MD Baltimore NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21217 U.S.A. 1600 West Mt. Royal Ave death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No item 27 is marked other than "natural", or i other traumatic event, the Medical Examin þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: Black 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. 77 is marked other than "r Baltimore City Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools 12th grade 4yrs Custodian Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Proctor Josephine Henson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a tant: If item 27 is 3477 Liberty Parkway, Dundalk Md 21222 Micheal Proctor-Grandson 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury or Department of Important: If any injury or Garrison Forest Vet 1/9/2012 Owings Mills, Md 4 Donation 5 Other (Specify) 22. Name and Address of Facility
March F/H West 21. Signature of Funer Service Lice 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1400944141 Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner GRTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events soulding in death). Examine physician and sthe burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No signed by the at Id be detached for 1 Yes 2 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PLACE - For SIKK Siny PACE MAKER W48 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an Syndrom, cate has by page 2 s autopsy performed? Yes 2 No DYERUNGTEON (Hyputingin certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To the Hospital or Attending Physician: Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 38086

State Registrar 419 W. REDWOOD St.

Suit, 620.

Balto, MD,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra 's Sign

ohas.

31. Date filed (Month, Day, Year)
JAN 0 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Schmidt Wilcox Dorothy December 6:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Edenwald **Towson** 9. Birthplace (State or Foreign Country) Maryland Social Security Number 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Hours Min. Days 1 □ M 2 🂢 F 220-32-3715 98 Director Yrs 1913 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Baltimore Towson ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 800 Southerly Road 21286 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ŏ ò 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural" Completed 3 XWidowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any hiury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Office Furniture Clerk years Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Russell Schmidt Hinkel Louise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry D. Focas Pennsylvania Ave. Towson, Maryland 21204 (Attny. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Druid Ridge Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Pikesville, Marvland 1-5-12 21. Signature of Funeral Service Licensee Name and Address of Facility Ltchell-Wiedefeld Funeral Home, In 500 York Road Baltimore, Maryland 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death complications from Vascular dementia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last The law requires that the death certificate be exe Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown cate has been sig 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? After this certificate 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner.of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) R154032 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 212860 - Scher CRNP Towson Southerly 800 31. Date filed (Month, Day, Year) 32. Figisu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ December BARBARA т. WASHINGTON 12:55 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Regional Hospita aure. Laurel 9. Birthplace (State or Foreign Country) New York Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 28,1931 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗓 F Months Days Min Hours **Director** 577-50-1883 80 Yrs Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits death with the Maryland **Funeral Director** Silver Spring 1 Yes 2X No Montgomery ò 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? 23a Countryside Court 20905-4516 USA items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2**XX**No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2XXX No Specify. Specify: Black 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Teacher D.C. Public Schools permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Stephen Thomas Sidortha Nolley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexander Washington/Husband Countryside Court, Silver Spring, MD 20905-4516 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗀 Burial 2 💢 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 12/31/2011 Odenton, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 20707 23a. Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Bowe Ischemic disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit oaqulopath Due to for as a consequence Physician/Medical piration neumonid Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No ☐ Live Birth 2 ☐ Fetal doc... ☐ Pregnant at time of death Month Day Year the g Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 X N certificate 2 No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Cther (Specify) မ 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Medical Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? After 1 XNatural (Month, Day, Year) 5 Pending 1 Tes 2 No after death Director; / Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in within 24 hours a

To the Funeral D

completed filled i

the

State Registrar 29a. Certifier

(Check

only one

29b. Signature and title of certifier

George I. OKang,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registra

Laurel Regional Hospital

XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

7300

aurel

29c. License numbe

29d. Date signed (Month, Day, Year)

December 29, 2011 Dusen Road

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December Day 28, 2011 6:35 P.M Robert John Weisner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Manchester 2209 Scenic View Drive Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month Day, Year) XX M 2 D F Months Days Hours Maryland Director Jan. 212-48-2276 64 Usual Residence of Decedent show 10a. State should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 2209 Scenic View Dr. 21102 America of 12. Was Decedent Ever in U.S. Armed Forces? 196 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1967 Black, White, etc. ģ 1 Never Married 2013 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1973 1 ☐ Yes 2XX No Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse Man Warehouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Weisner Mary (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Dietz Weisner (Wife) 2209 Scenic View Dr., Manchester, MD 21102 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State All Faiths Crematory & Chapel ☐ Burial 2XXCremation 3 ☐ Removal from State 12/30/2011 Manchester, Maryland er ice License 22. Name and Address of Facility Eckhar t Funeral Chapel, P.A. 21. Signature of Funeral may 3296 Charmil Dr., Manchester, MD 21102 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) estas Physician no carc Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to for as a nonsequence off cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death ate has been signed by the a page 2 should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 1 ☐ Yes 2 ☐ No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? 1 🗌 Yes Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 M Residence 6 Other (Specify) 27. Mannet of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury s after death. 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

onte

30; Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Physician/ Gloria 6:30 A M Lillian Worley 25, 2011 December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** St Elizabeths Nursing Home Baltimore . Social Security Number If Under If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min (Month, Day, Year) 217-09-4954 Director 1 □ M 2 🖫 F 16,1927 Pennsylvania Nov. 84 Usual Residence of Decede 28a-f show 10d. Inside City Limits 10a. State 10b. County aţ 10c. City, Town or Location death with the Maryland Director notified 1X Yes 2 □ No N/A MD Baltimore 5 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? be r items 23a Funeral 21230 USA must 2149 Harman Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify. 3 XWidowed 4 ☐ Divorced Completed Year or Dates Medical 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) the Montgomery Wards Retail Sales Be Filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary UKN Anthony Zinsavage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Keen Mill Court-Baltimore Maryland 21228 Pat Eisenhardt-Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 Burial 2 X Cremation 3 Removal from State Dec.28,2011 | Glen Burnie Maryland Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21, Signature of Funer ervice Lice 22. Name and Address of Facility Ambrose Funeral Home Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1328 Sulphur Spring Road Arbutus Maryland 21227 Interval Between Onset and Death -Phyllician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examir Cause (Disease or injury burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Day Year Pregnant at time of death ed by the a detached t Unknown 9 Unknown by 1. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 page performed?

1 Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗾 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 읻 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ours after death.

leral Director: Af

filled in by the fu 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) building, etc. (Specify) within 24 hours a

To the Funeral D Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 124781 December 27, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pine HE ONTI gre P. GRANANSE S300 BAUTINIRE m (00) 32. Registrar's Signature State

Registrar

11-09757 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 42140 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month **Medical Examiner** Month Day December 28, 2011 0812 hrs Sam Whatley, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7912 Heather Mist Drive Severn Anne Arundel 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country)Ohio Days Director Months Hours 1X M 2 F 56 Yrs October 3, 1955 268-56-4849 Usual Residence of Decedent in, 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Examiner must be notified at once. 1 Yes 2 X No Maryland Anne Arundel Severn with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country United States 7912 Heather Mist Drive 21144 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' White, etc. 1 Never Married 2 X Married 1 Yes 2 x No iss I and 2 should be filed within 72 hours after of Health and Mental Hygiene.

If item 27 is marked other than "natural", o 4 Divorced If Yes, Giva Year or Dates: 3 Widowed 1 Yes 2 X No specify: Black þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Real Estate 2+Real Estate Agent Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) other traumatic event, æ Callie Mae Henderson Sam Whatley, Sr. ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7912 Heather Mist Drive, Severn, Maryland 21144 Althea Whatley/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date permit. Pages 1 a
Department of He
Important: If it west Arundel Crematory January 5, 1 Burial 2 X Cremation 3 Removal from State 2012 Odenton, Maryland 4 Donation 5 Other Specify. 5 22. Name and Address of Facility
Donaldon Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21. Signature of Funeral Service Licenses 21113 M01386 23a Part I. Boter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician /Medical Between Onset and Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physiclan/Medical AMENDED 23a,pt.II,2/,per me,g923 I-I2-I2 sm UNPENDED #17perFH\_C924\_2/10/2012\_WS 23c. If yes, outcome of pregnancy The law requires that the death certificate be Box 68760. IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death the attending Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 ✔ Unknown Diabetes Mellitus Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? page 2 performed Yes 2 V No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital B examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other<sub>4</sub> Nursing Home 5 Residence 6 🗹 Other: Scene this DOA 2 No ٩ 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 Yes 2 No hours after death. Director: d in by the f 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined Fo the Funeral 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 24 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E December 29, 2011 30. Name and address/of person who completed cause of death (Item 23a)

State Registrar egistrar's Signature

900 W. Baltimore Street, Baltimore, MD 21223

Pamela E. Southall, MD Assistant Medical Examiner

31. Date filed (MoJANY 0ea 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 9:10 A.M Physician/ ARTON Medical 4b. City, Town, or Location of Death 4c. County of Death Eacility Name (if not institution, give street and number) **Examiner** BALTIMORE Manor Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours -10-2811 **Director** -10-1922 SALTI MORE. ML Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location must be notified at Director 1 Yes 2 No WD TOWSON TIMOR 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a Funeral 21204 ton death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedon... Armed Forces? ¹ ☐ Yes 2 🕏 No the Medical Examiner Black, White, etc. 9 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates "natural" Completed 3 ₩Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) မ e 19b. Mailing Address (Street and Number or Rural) oute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or orth 10W50 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State Forest Hill 36/11 4 Donation 5 Other (Specify) YORK RA, MONKTON MD ZILL . Signature of Funeral Service Licensee · CREMATION SERVICES-Monkton ha Frans tune 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final-Physician/ years Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: attending 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Year Month ò Dav signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform 2 🗌 No 1 🗌 Yes certificate Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be KESILLEG IMIN examiner's 10L Hospital 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sp To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this: 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 1 Natural 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifie 29c. License number eccurber 24 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAZVES 6701 N. 2 AARON NOWST JAN 0 3 32. Registrar' Signatur

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 26 per doc g923 1-3-12 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician/ Dorothy Wiley 20 11 December Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** TIMORE PARKTON ANdrews ourt 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 26-2046 **Director** 1 🗆 M 2 🕱 F 86 Rocky Kidge MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County Completed by Funeral Director 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Numbe 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married 1 Yes 2 No Specify. 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) nom e tomemake Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ark MD ORMa 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 30 4 Donation 5 Other (Specify) 22. Name and Address of Facility/62 2 4 YOLKED, MONKTON Signature of Funeral Service Licenses CHAPEL+ CREMATION 23a. Part 1. Enter the disease or co shock, or heart failure. List only foligations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Physician/ Stomach Council disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? eral Director: After this certificate has been signed by the atter filled in by the funeral director, page 2 should be detached for 1 Yes 2 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has t autopsy 25. Was case referred to medical 26. Place of Death (Check only one) examiner? daughter's Other: 4 Nursing Home 3 nesidence 6 A Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check ns Ryap Mun.D 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12/29/11 10057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.S. Rayapa KLL M.D. 2875 S.M.I.D. DV 5203 Balamore MD Z1209

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 0410 AM **Physician** 145+18 Williams December 26 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😾 F Months Days November 30,1922 89 Baltimore, Maryland Director 219-18-4818 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be processed. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Sparrows Point Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code United States 21219 5 Short Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Harford Boiler Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Company Key Punch Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rachel Jane Stuart Robert Spencer Vinton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5 Short Lane Sparrows Point, Maryland 21219 Elizabeth Vinton (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State December Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 29, 2011 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Evans Funeral Chapel & Cremation
8800 Harford Read Parkville, Me

23a. Part 1. Enter the disease, or complications that caused the death. Shock, or Hear failure. List only one cause on each line. Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia **Physician** \_om Wrek \_ √/Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) physician and is the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical for use as IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Tectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2√ No Pregnant at time of death 5 Other (specify) Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ ge, 2 No 3 Probably 4 Unknown 1 ☐ Yes should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Jas page 2 🗌 No 1 Yes 1 Yes certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home Hospital: 1 ☐ Yes 2 No 1 Inpatient 3 🗆 DOA 5 Residence 6 Other (Specify) 2 ER/Outpatient မ this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 24 hours after death. Funeral Director; After Injury Natural 2 Accident 5 Pending investigation M 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Cify or Town, State) To the Hospital 1 Scritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

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11595

State Registrar

DHMH 17 Rev 1/2001

December 26, 2011

4940 Eastern Avenue, Baltimore, MD, 21224

'WD

32. Registrar Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ECHMBER 27 201 Wyatt Myrtle Mae Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Anne Arundel Baltimore Washington Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗶 F MD Director 218-30-7084 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 No MD Anne Arundel Severn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 23a Funeral U.S.A. 21144 7909 Clark Station Road death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. ō 1 Never Married 2 Married þ Yes 2 X No Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White ed other than "natural", event, the Medical Exar 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be permit. Page 1 and 2 should be fliet
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other transcript 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ida Μ. Blunt. 0. William . Bussey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pasadena, MD Mr. Wayne Wyatt / Son 554 Cardinal Drive 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 12/31/2011 4 Donation 5 Other (Specify) Glen Burnie, MD 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Deleno Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events resulting in death) Last -transit and physician a sthe burial-1 Physician/Medical certificate be Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death been signed by the should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Impatient 2 ER/Outpatient 3 DOA 1 Yes မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural Hospital or Attending 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Oertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print)

HOSTIFAL

OFFICE SOI HOSTIFAL Drive GLENBURNIE, 31 Date filed (Month, Day Year) State JAN 0

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 31, 2011 6:04 AM Waller Mary Lou Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice of Towson If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 219-28-6733 1 🗆 M 📈 F 78 8/28/1933 Maryland Director 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f shorex aminer must be notified at 10a. State 10c. City, Town or Location the Maryland Director XX Yes 2 No Baltimore City Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21212 7020 Bellona Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XX No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White "natural" Completed 3 Widowed XX Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cemetery 12 Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Thelma Moreland Lou Bierman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a t: If item 27 is or other trau Baltimore, MD 21212 Mr. Michael Gianakos / Son 7020 Bellona Ave 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date XXI Burial 2 Cremation 3 Removal from State Department of Important: If any injury or Glen Haven Mem. Park 1/4/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Signature of Funeral Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 N601220 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ END STAGE PARS disease or condition resulting in death) BSTRUCTIVE Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to for as a consequence of if any, leading to immediate cause. Enter Underlying burial-transi Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) signed by the at the detached for g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobaceo use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown plnous peen 24b. Were autopsy findings available 24a, Was an cate has to page 2 s prior to completion of cause of death?

1 Yes 2 No autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Aatural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No. Investigation Accident filled in by the Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Date filed (Month, Day, Year,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Elizabeth Wellham 2:12 A M 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Linthicum N. Camp Meade Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours Director 220-07-0139 1 □ M 2 X F Yrs 07/02/1920 MD 91 Usual Residence of Deceden or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 Yes 2 No Linthicum MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò must be r Funeral 21090 U.S.A. N. Camp Meade Road nan "natural", or items ? Medical Examiner mus within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) the Board of Education Supervisor other Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental ၉ Department of Health and Ment. Important: If item 27 is marked any injury or other traumone. Fannie Welsh William Wilson Wellham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linthicum, MD 21090 6115 Medora Road Mr. Robert K. Wellham / Nephew altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery | 01/04/2012 | 4 Donation 5 Other (Specify) Baltimore, Maryland 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Singleton Funeral & Cremation Services, P.A. M01121 23a. Part 1. Enter the disease, or or manications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ etartahi of eno carcinome n disease or condition Medical resulting in death) to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical certificate be P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mo Month Day 5 Other (specify) Pregnant at time of death signed by the at Id be detached fo Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Yes Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 page 2 s death? or Attending Physician: The after death.

Director: After this certificate h filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 A 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No ☐ Accident ☐ Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigati on, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check geath occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, 3 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifie Glen Burnie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ₩ 0 1600 South Crain Highway Suite 106 Maryland 21061 DC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2012 JAN 0 Registrar

DHMH 17 Rev 06-2011

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Baltimore, MD 21215-0036  nermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any	Be Completed by Funeral Director	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade con										
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21 Ould I Mer	2 2	19a. Informant's Name/Relationship (Type, Print ) ( S15										
Baltimore, MD 21215-0036 remit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene.	To Be	Latrice & LaKish Wallad										
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altin mit. P. partme	o ( m)	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee										
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al Residence of Decedent 10b. County 10c. City, Town or Location N/A Baltimore Street and Number 10f. Zip Code 507 McCulloh St. 21217 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Never Married 2 Yes 2 X No 4 Divorced Widowed If Yes. Give Year Yes 2 X No specify: . Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) lementary/Secondary (0-12) College (1-4 or 5+) Oth Grade Car Wash Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) aymond E. Wallace III Helen Unk Informant's Name/Relationship (Type, Print ) (Sisters) 136 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2927 trice & LaKish Wallace McCulloh St., Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 8urial 2 Cremation 3 Removal from State on-site Crematory Donation 5 Other Specify Signa)ure of Funeral Service Licensee <sup>22</sup> Name and Address of Facility

Joseph H. Brown Jr. Funeral Home PA 2140 N. FUlton Ave., Baltimore, MD21217 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line a Multiple Gunshot Wounds nediate Cause (Final disease condition resulting in death) Due to (or as a consequence of): uentially list conditions, ny, leading to immediate use. Enter Underlying Cause Due to (or as a consequence of): sease or injury that initiated Due to (or es a consequence of): ints resulting in death) Last UNPENDED AMENDED this certificate has been signed by the attending physicial director, page 2 should be detached for use as the burial Physician/Medi Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> Completed 24a. Was an autopsy 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 PER/Outpatient 3 1 🗸 Yes DOA ဥ 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Certification: Dec 24, 2011 1 Natural Subject shot 2300 hrs 1 Yes 2 ✔ No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be determined (Specify) outside of residence 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. g 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

amend # State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

7. Age (In yrs, last birthday)

30

4b. City, Town, or Location of Death

If Under 1 Year If Under 24Hrs.

29c. License number

O.C.M.E.

Hours

**Baltimore** 

Months Days

4c. County of Death N/A 8. Date of 8irth(MM/DD/YYYY) 9. 8irthplace (State or Foreign Country) MD /14/1981 10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country? U.S.A. 14 Race - American Indian, 8lack. White, etc. Specify:Black 16b. Kind of 8usiness/Industry Quality Car Wash Baltimore, MD 21217 20c. Location - City or Town, State Baltimore, MD Approximate Interval 8etween Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown 24b, Were autopsy findings available prior to completion of cause of performed? ✓ Yes 2 No death? 1 🗸 Yes 2 No Other Nursing Home 5 Residence 6 Other: 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2700 Giles Road, Baltimore, MD 29d. Date signed (Month, Day, Year) December 25, 2011 Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

42147

3. Time of Death

2350 hrs

Reg. No

Month Day December 24, 2011

2. Date of Death

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

OGME

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Ana Rubio MD.

31. Date file

and manner stated

32: Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dec. Yuet Amenda Yung 30, 2011 8:40 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 16517 Killdeer Drive Derwood 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours Min (Month. Day, Year) **Director** 555-75-9537 1 🗌 M 2 🗶 F Yrs. 1970 41 Feb 8, China 28a-f show the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 No Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 16517 Killdeer Drive 20855 United States permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 12 Yes 2 1 No (unk)
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married ρ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Chun Yam Yung Cheng Moy Wong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig A. Hanson / Husband 16517 Killdeer Dr. Derwood, MD 20855 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 1/4/2012 Woodbine, Maryland 21. Signatur Funeral Service Lice Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) 8 years Breast Cancer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injur use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) for in the past 12 month Pregnant at time of death Month Day Year signed by the ar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autonsv perform 1 Yes 2 X No 1 Yes 2 No Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 5 Pending 1 🗶 Natural injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical within 24 hou To the Fune completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) D45880 January 3, 2012 address of person who completed cause of death (Item 23a) (Type, Print) and 9+1 Leon Hwang 1396 Piccard Dr. Rockville, MD 20850

State

DHMH 17 Rev 06-2011

Registrar

JAN 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 23, 2011 December 1:10 P M Elvira Mamani Zela de Yucra Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Gaithersburg 8206 Shady Spring Drive If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Hours Jan 23, Peru 1930 Director 216-31-0652 81 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o edical Examiner must be Funeral 8206 Shady Spring Drive 20877 Peru Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married ģ 2 🔀 No Yes Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify: Specify: White If Yes, Give 3 X Widowed 4 Divorced Completed Peruvian Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Registered Nurse 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Maria Zela Jose Mamani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8206 Shady Spring Dr. Gaithersburg, MD 20877 Elvy Cancelado / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Journey Crematory 12/31/11 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Final Signator of Funeral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 🎛 No ģ Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy perform Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🔀 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work?
1 Yes 2 No 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number 4 Homicide determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number December 29, 2011 D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. Coleman 1355 Piccard Dr. Rockville, MD 20850

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 23, 2011 11:30<sup>A</sup> Esther Zeiler W. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis- Homewood N/A Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min June Day Year 919 Virginia 220-22-7990 92 Director Usual Residence of Decedent shov 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits notified at Director N/A 28a-f MD 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be Funeral 23a 6000 Bellona Avenue 21212 United States 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 XNever Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natum any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John L. Zeiler Virginia P. Breeden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Wathen, Sr. 22860 Cedar Lane Ct. Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December Evans Funeral Chapel - Bel Air 1 Burial 2 X Cremation 3 Removal from State Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 27,2011 Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 allau 29a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atherosclerotic candiova sculan disease diate Cause (Final Physician/ se or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant : Pregnant at time of death 9 Unknown within 24 hours after death.

To the Funeral Director; After this certificate has been signed by to completed filled in by the funeral director, page 2 should be detact. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature applitle of certifie 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Fairmount AV SAFI. Baltimore MD21204

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1246 PM Hinderson CKSON Michael Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death IVISTA Medical Plata harles enter 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign ial Security Number Date of Birth **Funeral X**M 2 □ F (Month, Day, Year, Months Days Country. **Director** infant mamland Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Me Ical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 💢 No MD Saint Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20659 USA 26220 Clarkes Village Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene, 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) infant infant infant infant Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anderson Marie Michael Denise Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 GArrett AVenue LaPlata, MD 20646 ge 1 and 2 sl it of Health a If item 27 is Civista Medical Center Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in state Signature of Funeral Service Licenses 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street ✓Director Baltimore, MD  $_{21201}$ Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock. rt failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Extreme Prematuntu disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year ed by the a detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed d be det 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed' certificate 2 No 1 Yes Yes To the Hospital or Attending Physician: Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funeral completed filled in by the funeral completed filled Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Qay, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Clarice R. Arnold Physician/ December 29, 2011 1:44 Рм Medical 4a. Facility Name (if not institution, give street and number)
Gilchrist Hospice 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 02/22/1926 Hours MD 85 Director 1 🗆 M 2 💢 F 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Allegany Cumberland 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9 ms 23a or must be n Funeral USA 21502 612 Holland Street items 2 be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status the Medical Examiner Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White "natural", 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Medical Transcriptionist Healthcare event. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 William Rothe Sara Louise Eccleston injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) Hugh M. Arnold, Jr. / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
612 Holland Street, Cumberland, MD 21502 Department of Health an Important: If item 27 is any injury or other trau 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Page 1 ; cemetery, crematory or other place, 1 Burial 2XXCremation 3 Removal from State 12/31/2011 |Beltsville, MD Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) Marshal Signature of Funeral Service License DOYO La 22. Name and Address of Facility Paryland Cremation Services PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical Examiner resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir anding physician and use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death signed by the at Id be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2 autopsy performed? Yes 2 No • Hospital or Attending Physician: 24 hours after death.
• Funeral Director; After this certified funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence ဂ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2. nly one 29c. License number 29d. Date signed (Month, Day, Year) Signature ar 12-29-11 Name and address of person who completed cause of death (Item 23a) (Type, Print) Swite 4105, Baltimere, MO 21204 6701 31. Date filed (Month, Day, Year) State

Registrar

Physician/

Medical

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MD

Director

Funeral

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Examiner

**Funeral** 

**Director** 

28a-f show

iral", or items 23a or 28a-f sho Examiner must be notified at

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and Mental Hygiene. is marked other than

permit. Page 1 and 2 should be file.
Department of Health and Mental Humportant: If item 27 is mariany injury or other.

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executed that the death certificate be Box 68760 P.O. Records, **Division of Vital** or Attending To the Hospital

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu State

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Dec.30,2011

31. Date filed (Morth Pay, Year)

30. Name and address of person who completed

Registrar's Signature

cause of death (item 23a) (Type, Print)

Registrar

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an	be file lental rked c	Tol	Vaughn Barri	,						lah N.		,				
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationsh Franklin Square									City or Town, State, Zip Code) osedale, MD 21237				
more,	age 1 and ent of Hea nt: If item y or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ※ Other (S	3 Removal from	State C		osition (Name of matory or other pla	ice)	ı	Date	20c. Loc	ation - City or	Town, State	<u>;</u>		
Balti	permit. F Departm Importa any injui		21. Sign to a Funeral Strice L				Name and Addre				V. Bal	timore	Stree	et		
-			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that c	aused the deat		altimore er the mode of dyi				arrest,		Approxi	mate Between		
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market State of State	Medical Examiner		resulting in death)  Due to (or as a consequence of):													
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687	ertific iding p	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	23c. If <u>yes</u> , outcome of pregnancy							2d Data of d	distant.			
Box	requires that the death certificate I been signed by the attending phys should be detached for use as the	by Physician/Medio	in the past 12 months?  1  Yes 2 No 9 Unknown	4 ☐ Pregr	1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							23d. Date of delivery  Month Day Yea				
О. О.	that the	y P	Part II. Other significant conditio	ns contributing to de	eath but not res	ulting in the u	ınderlying cause g	iven in Part	t I.	23e. Did	23e. Did tobacco use contribute to the cause					
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Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the Medical Certificate: To Be Completed by Physician/Medii			1 Natural 5 ☐ Pending 2 ☐ Accident Investig	ation	(Month, Day, Year) injury work?  n					Zod. Describe now injury occurred						
			3 Suicide 6 Could r 4 Homicide determi	28e. Place							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
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	e Hos n 24 ho e Fun oletely	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) are considered. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											I manner state		
	To th within To th comp	<	29b. Signature and title of certifier		29c. License number							signed (Mont		)		
			1 9 There	V							12/211					
			30. Name and address of person v	· ·	e of death (Item	23a) (Type, F	Print)	-			2 2		. 0 -			
	Stat	e	DR Jaines ETh. 31. Date filed (Month, Day, Year)	<b>₽</b> 32. Re	90 egistrar's Signat	ture	RANKLIL	1 2 Q	لذودة	e Di	N 120	CTO W	rd Z	1621		
	Registra		JAN 0 4 20	12 Sent	egistrar's Signat	par										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 043 M Mon Physician/ BART LLI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 927 Perry Landing Ct Annapolis Arundel <u>Anne</u> 8. Date of Birth (Month, Day, Year) Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min Hours **Director** 129-14-8604 1 🗆 M 2 📝 F 86 Mar 29, 1925 Texas Usual Residence of Deced or 28a-f show 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location the Maryland Examiner must be notified at Director MD Anne Arundel 1 Yes 2 No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a death with 927 Perry Landing Ct 21401 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itemany injury or other traumatic event. 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: Specify: white 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry unk (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 4 public relations Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည William George Michael Hogan Madge Amanda Hay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandrid Ross-Baer/daughter 1108 Ruthsburg Road Centreville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 X Donation 3 Tother (Specify) 22. State Achae らかり Board 655 W. Baltimore Street Rob 1 d Sicen de √ Director 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ST Ph. i.i.n ROKE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CARS PERTENSION Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to or as a conse juence of and burial-trai Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy t 12 months? in the past 12 Year Month Day Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an page 2 autopsy performe Yes 2 filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🗌 Nursing Home 5 🗌 Residence (tr)mE 1 Yes 2 - NO ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural work? 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practition To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) Signature and title of 29b D 11438 me and address of pers d cause of death (Item 23a) (Type, Print) who complet ANNAPOLISMOZIYO DEFENSEHWY 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death BROWN Physician/ 30 Day Medical **Examiner** 4b. City, Town, or Location of Death County of Death 5000 Hollington Drive, Apt. 205 Baltimore Owings Mills If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral Director** 1**X** M 2 □ F 1953 "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director Mills MD Baltimore OWINAS 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code Drive, Apt. 205 ttollington US death with 21117 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced permit, Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Stars 12th grade alent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Herbert Brown Shirley Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur Route Number, City or Town, State, Zip Code) Shirley Wood 5000 Hollington Drive, Apt. 205, Cwing Hills MD 2117 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 01/04/2012 Baltimore, MD 4 Donation 5 Other (Specify) C. Evelne funcial services 21. Signature of Funeral Service Licensee acility Vaughn Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or lear failure. List only one cause on each line. Approximate Immediate Cause Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown the Unknown Records, P.O. ı signed by tl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas page 2 performe this certificate 2 🗌 No Yes 2 X 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ပ 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After 1 Natural 5 Pending nours after death.

neral Director: Af 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 .Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Gertifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Gertifying Nurse Practitions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 29b. Signature and title of certifie completed cause IDV 31. Date filed (*Month, Day, Year*) **JAN 0 4 2012** State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1802 Medical 4a. Facility Name (if not institution, give street and **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth Funeral birthday 9. Birthplace (State or Foreign 1 X M 2 □ F Month, Day Year Country) Director Usual Residence of Decedent 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County Completed by Funeral Director 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified Randallstown Baltimore 1 Yes 2 No 10f. Zip Code 2133 5 10e. Street and Number 10g. Citizen of What Country? Road 4126 Tiverton USA "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry State of Markand (Give kind of work done during most of working marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Securit clifton Devisions 12th orade 2 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) 2 Emest Burd Georgia Bruce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f124 Tiverton Road Kan dallstown MD 21133 1ean 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1:
Department of I
Important: If it
any injury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 01105/2012 Owings Mills, MD Garrison Forest VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaudn C. Greene Fundal servico 8728 Liberty Read Kandalstown MD21132 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, ir heart, ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Carse # inal Physician/ disease or condition Medical resulting in death Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of influry that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): the bunalthe attending physician hed for use as the bunal Be Completed by Physician/Medical Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Day Month Year detached 1 L Yes 2 L 9 Unknown Unknown P.O. Atter this certificate has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.
To the Funeral Director; After 1 Natural 5 Pending 1 Yes completed filled in by the Accident Investigation 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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Physici Medical Exami											Month Day Year December 25, 2011					
		4a. Facility Name (if not institutio 555 South Atwood Ro	n, give street and n	umber) it 419	4	b. City, Tow Bel Air	n, or Lo	ocation of I	Death		- 1	c. County o	f Death			
		Social Security Number	6. Sex	7. Age (In yrs. I	ast hirthday)	If Under 1	Year	If Under 2	24Hrs	8 Date of B		//DD/YYYY)	9 Birt	tholace (S	tate or	
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re, s 1 and f Heal ff iten er tra		20a. Method of Disposition  1 X Burial 2 Cremation	3 Removal f		Place of Disposi crematory or oth		of ceme	etery,	!	Date	200	. Location -	City or	Town, Sta	nte	
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ex		4 Donation 5 Other Sp			. Air Me				12/2	29/11	В	el Ai	r, N	Maryl	and	
Salti ermit epartn mport ijury		21. Signst Funeral Service		9	22. N	ame and Ad ICCOMA	dress of F	f Facility	l Ho	ome, F	.A.					
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Physician Medical		failure. List only one cause	on each line.								,			Betwee	en Onset and Death	
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To the within To the compl	28e. Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number or Rural Information of Town, State)  28g. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month,															
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo  Co.C.M.E.  December 28, 20															
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41		30. Name and address of person Ling Li, MD Assista	who completed cau nt Medical Exa			e Street,	Baltir	nore, M	D 212	23						
S	tate	31. Date filed (Month, Day, Year)	3€.R	egistrar's Signat	ire .											
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** December 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give Examiner Johns Hopkins Bayview Medical Center **Baltimore** N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 X M 2 □ F 219-32-8385 Director 73 Oct. 7,1938 <u>Maryland</u> Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Examiner must be notified at 1 Yes 2 X No Director MD Baltimore Dunda1k 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ō 23a 8127 Cornwall Road Funeral 21222 United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No 14. Race - American Indian Black, White, etc. 1X Yes If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'n, 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Year or Dates "natural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education other than "natu (Specify only highest grade completed) Baltimore County Elementary/Secondary (0-12) College (1-4 or 5+) Law Enforcement 12 Years Years Baltimore County Police 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked or traumatic ever Catherine A. Adams James P. Bugosh, Sr. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) it of Health a Mrs. Carolyn Joan Bugosh (Wife) 8127 Cornwall Road Dundalk, Maryland 21222 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important; If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem: 1/3/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland 23a art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** /Medical resulting in death) Due to ( r as a consequence of) **Examiner** Secura folly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) detached 1 2 No Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ð 4 Unknown 2 No 3 Probably 1 Tes been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe ate has page 2 1 🗌 Yes 1 🗌 Yes 2 🗌 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2 No 1 Tes 2 ER/Outpatient 3 🗆 DOA 5 Residence 6 Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 Tyes 2 🗌 No Accident after death I Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a

To the Funeral C

completely filled Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical (check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person v cause of death (Item 23a) (Type, Print)

W

Registrar

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** dward Bowling Dece 28 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

(Month, Day, Year)

Sept. 21, 1941 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F Days Months Hours Director 220-38-6274 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "material" in any Injury or other terms. 10a State 10d. Inside City Limits 10h Counts 10c. City, Town or Location Terra Alta 1 Yes 2 No Preston Director WV 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? United States 26764 Funeral 6451 Aurora Pike 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No þ 3 ☐ Widowed 4 X Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City Maintenance Roads Dept. 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Genieve D. Houck Joseph F. Bowling ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8480 Miramar Road Pasadena, MD Mr. Michael Bowling (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corp. 1/4/2012 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22 Name and Address of Facility al Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Filter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dirator disease or condition resulting in death) /Medical Due to (of as a consequence of): **Examiner** neu mon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): of Unknown Origin Sta tic burial-tran resulting in death) Last physician Division of Vital Records, P.O. Box 68760. Physician/Medical the as the attending use 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Tetal death 3 - Ectopic pregnancy in the past 12 months? Month detached for Day 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 the funeral director, page 2 should be 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2.X No မ 1 npatient 2 ER/Outpatient 3 DOA Director: After this 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28a. Date of Injury 28b. Time of 5 Pending investigation To the Hospital or Attending 1 Natural 2 Accident (Month, Day Year) Injury death. 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. filled in by 4 Homicide City or Town, State) hours after within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

State

parke

4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 0 4 2012

ANDREAS

31. Date filed (Month, Day, Year)

BARTH,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bollack C. Edward Month Physician/ 5:50 PM 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Franklin Kospdale male 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Yes Days Country Maryland 1 1 M 2 - F Months Hours 217-20-3595 85 1926 **Director** June Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. County 10c. City. Town or Location Director 1 ☐ Yes 2 🔀 No Dunda1k Baltimore MD 10g, Citizen of What Country? 10e Street and Number 10f. Zip Code Funeral 1249 South 48th Street United States 21222 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 6 Years College (1-4 or 5+) Steel Industry Forklift Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Adam Bollack Bette Mauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 Dundalk, Maryland 2804 Kirkleigh Road Janet Byron (Niece) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, MD Glen Haven Cemetery 12/31/2011 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Eacility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 21. Signature of Funeral Service License 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one caus Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition TOY Medical resulting in death) Due to (or as a consequence of Examiner monia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Exami Cause (Disease or iinjury bunal-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical death certificate be P.O. Box 68760 the as use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No p Month Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ requires Division of Vital Records, 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law page 2 s autonsv performed? death? within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 2 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. May er of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 / Natural injury 5 Pending 2 No ☐ Accident☐ Suicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO

7 h

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

in Square Drive Balto.

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Box

P.0.

of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Brown 5:50 A M Elizabeth December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Regional Hospita Laurel Laure 5. Social Security Number 7. Age (In yrs. last birthday) 62 Yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 □ M 2**X**□ F Hours 1 1 / 09 / 1 949 577-66-6812 Director Usual Residence of Decedent 10c. City, Town or Location Washington or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10h. County 10d. Inside City Limits Director 1X Yes 2 ☐ No 10f. Zip Code 20032 10e. Street and Number 10g. Citizen of What Country? Funeral 1329 Barnaby Terrace SE USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1XX Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done duning most of working life. DO NOT use retired)
FOOD Service Specialist 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Be 17. Father's Name (First, Middle, Last) Ernest Brown, Sr. 18. Mother's Name (First, Middle, Maiden Surname) ပ Ola Brown 19a. Informant's Name/Relationship (Type, Print)
Anita Hayes / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13300 Arden Way, #6, Laurel, MD 20708 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 12/31/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD of Funeral Service Licens Marshall ter 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Ph\_sician/ Septicemi Weeks disease or condition Medical resulting in death) Due to (or a a consequence of Examiner neumoni weeks Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Month Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ End Stage Renal Disease On Hemodialysis 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has ral director, page 2: autopsy perform Seizure Disorder 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one 29b. Signatu and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0057216 December 22, 2011 address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen V Baaka Michael Regional Hospital Laurel State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend # 17 Per FH G923 1/10/2011 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3Day Year PM 2011 Barbara J. Boardwine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rosedal FRANKLIN SQUAFE Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) 219-26-1696 Director 1 □ M 2 □**X** 73 2-7-1938 Usual Residence of Deced KY show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 No MD Dundalk Baltimore 10e, Street and Number 10f. Zip Code 5 10g. Citizen of What Country? must be r Funeral 2929 Yorkway USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status th and Mental Hygiene. 27 is marked other than "natural", or itel traumatic event, the Medical Examiner. Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify:White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Sewing Factory Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic s Buck Boardwine Burl Bradburn Mary Dorothy Gluszek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Burnell Gipe</u> 2929 Yorkway Dundalk Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Bayview Crematory 1-2-12 Dundalk, MD 21. Signature Funeral Service Lic. <sup>22. Name and Address of Facility</sup> Connelly FH of Dundalk, P. 7110 Sollers Point Road Dundalk, MD 21222 na MO1176 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between rediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Se PSIS Medical Due to (or as a consequence of): Examiner Bowel Ischemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): eritonitis burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buris Physician/Medical death certificate be LIVER Dysfunction P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Non Small Cell Lung Cancer Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Peripheral Vascular Disease 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performed Coronary Artery Disease this certificate Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending 2 Accident
3 Sulcide
4 Homicide 1 Yes 2 No Investigation 24 hours after death Funeral Director: / filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse-Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 the only one) within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOO 53694 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Daniel L. Shinners

31. Date filed (Month, Day, Year)

JAN 0 4 2012

BOALDWIN

32. Registrar's Signature

9000 FRANKLIN Square DR Balto md 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death December Physician/ 201 5,20 AM Medical Facility Name (if not institution, give street and number) or Location of Death **Examiner** 4c. County of Death, 7 Mol Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number **Funeral** Month Min Country) Director 1 M 2 S 96 March 28a-f show items 23a or 28a-f sho her must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Homore 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 21229 enism 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Examiner Black, White, etc ŏ by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", 3 Widowed 4 □ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Be . Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname, ည Saac other traumatic 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st. Department of Health an Important: If item 27 is any injury or other trau Brownstone 2606 20b. Place of Disposition (Name of 20a. Method of Disposition 20c, Location - City or Town, State 2 Cremation 3 Burial Baltimore Donation 5 Other (Special) of Funeral Serv 22. Name and Address of Facility 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final nset and Death Ph sici n disease or condition resulting in death) To EW WEEKS Medical Examiner Sequentially list conditions Examine Due to for as a consection of cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last burial physician Physician/Medical Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant in the past 12 pronths? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by the ld be detach. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death' certificate ! 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospita Other: 2 No မြ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 44 Nursing Home 5 Residence 6 Other (Specify, After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 5 Pending injury death. the Funeral Director: Anpletely filled in by the 1 Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of c 29d. Date signed (Month, Day, Year) 00062634 MI DEC 31, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATBISM AWAY (1979) 4 MATERN 10796 CILUMBIA HICKORYRIDGE AD Mn 21.44 32. Registrar's Sig State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ :19A.M 2011 Mary Helen Broache Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALLIMORE, MAR 8. Date of Birth 9. Birthplace (State or Foreign Funeral 219-10-7314 1 □ M 2 🛛 F (Month, Day, Year) 25 Maryland Director 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 21228 1216 McCurley Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sedonia Mullineaux Navy Francis Xavier Banvard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $4604\ Wilmslow\ Baltimore,\ MD\ 21210$ 4604 Wilmslow Stephen Broache Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 1/7/2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. ce of Funeral Service License M01010 1630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset Ind Death Immediate Cause (Final Physician Arteriosclerotic disease or condition a. Coronary Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): attending physician and I for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be IF FEMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 moeths?
1 Yes 2 No
9 Unknown ate has been signed by the atte page 2 should be detached for Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe this certificate has Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes Certificate: To ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury 5 Pending 1 Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who come

Year)

31. Date filed (Month, Day,

leted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>D</sup>30 Physician/ December 20T1 12:10 PM Gerald Winfield Curry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard 8398 Commercial Street Savage Birthplace (State or Foreign Country) MD Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Min 01-30-1943 1 🗶 M 2 🗆 F Months Days MD 217-38-3407 Director 68 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 X No MD Howard Savage ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral with 8398 Commercial Street 20763 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc. ò 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. ò 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: "natural" 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Howard County Fire Dept Fireman traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o မ Elizabeth Reilly Bedford D. Curry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 8398 Commercial Street, Savage, MD 20763 Barbara A. Curry - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. cemetery, crematory or other place, 1基XBurial 2 ☐ Cremation 3 ☐ Removal from State Savage Cemetery 01-03-2012 Savage, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death
6\_months Immediate Cause (Final Physician/ Non Hodgkin Lymphoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate Cause (Disease or linjury Due to (or as a consequence of). g physician and as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth Z L recan Local Pregnant at time of death in the past 12 months? Month Year 2 No be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 **N**No 1 Yes 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 A Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending 1 X Natural 5  $\square$  Pending injury work' 1 Pyes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Example 2 Medical Examiner: On the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature to title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 01-02-2012 D-41119 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Sharma, MD, 106 Irving St., #418, Washington DC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Vaughn McQuay Conrad 2011 4:35 PM Dec. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 7795 Pennisula Expressway Apt. 307 Dunda1k If Under 1 Year | If Under 24 Hrs Months Davs Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) **Director** 217-26-7467 1 X M 2 □ F Aug. 5,1924 Maryland Usual Residence of Decedent 28a-f show 10b. County 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10c. City. Town or Location notified at Dunda1k MD Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a United States 7795 Pennisula Expressway Apt. 307 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō ò 1 Never Married 2x Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced WWII White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Steel Industry Bricklayer 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harry Conrad Violet Towers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delta, PA 17314 P.O. Box 108 Sherri Conrad (Daughter) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date X Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important: If any injury or 1/4/2012 Baltimore, Maryland Oak Lawn Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Duda-Ruck Funeral Home of Dundalk, Inc. licha Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between O tand Death Immediate Cause (Final Physician/ rech disease or condition resulting in death) Medical s a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 TYes 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Hospita 2 🗷 No Other: ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Director: After injury 1 Natura 5 Pending 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Understanding Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

bind

730

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4:15 M Anthony Gerard Cascio December Medical 4a. Facility Name (if not institution, give street an ation of Death 4c. County of Death Examiner If Under 24 Hrs. 6. Sex If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F Days Country Months Min (Month, Day, Year, 9-6-1958) 212-76-2924 53 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No MD **Baltimore** Catonsville 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 707 Long View U.S.A. 21228 items filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Was Decedent Armed Forces?
1 ☐ Yes 2 🗶 No Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò ρ 1 Never Married 2 Married 1 Yes If Yes, Give timore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates nd Mental Hygiene.
s marked other than "natura umatic event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) IT Software Engineer permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Vincent Frank Cascio Mary Liberto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 Long View Dr., Catonsville, MD 21228 Brenda Cascio/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Lake V1ew 1 X Burial 2 Cremation 3 Removal from State 1/3/2012 Sykesville, MD 4 Donation 5 Other (Specify) <u>Memorial</u> Park 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave. Catonsville, MD 21228 21. Signature of Funeral Service Licenses 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwoods and De shock, or heart failure. List only one cause o Lach line Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death signed by the at d be detached for 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II Other significant conditions sulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes Records, should Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 certificate has • Hospital or Attending Physician: The 124 hours after death.
• Funeral Director: After this certificate h Division of Vital 25. Was case re examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital ည 1 Yes 2 ER/Outpatient 3 DOA patient Date of injury (Month, Day, Year) 27. Monno of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at injury Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only one 29b. Signature State JAN 0 4 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:30 AM Physician/ Chrissomallis Derembe **Epaminondas** Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner Saint Joseph's Medical Baitimore enter 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Hours Mir 055-54-8752 **Director** 1 X M 2 D F 77 March 19,1934 Greece Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d Inside City Limits within 72 hours after death with the Maryland 10a State 10c. City, Town or Location Director Parkville Md. Baltimore 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21234 15 Top Wood Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2x Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. Entrepreneur Self Employed 2 vears 12 years Be filed \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental P 27 is marked o 2 Panayota Psareas John Chrissomallis Page 1 and 2 should be f nent of Health and Menta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sophia Chrissomallis Wife 15 Top Wood Court, Baltimore, Md. 21234 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or oth once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) January Baltimore, Maryland Oak Lawn Cemetery 3, 2012 21. Signature of Funeral Service Licens e Name and Address of Facility
Connelly Funeral Home of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. nan M01176 29a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Between Onset and Death Immediate Cause (Final Acute Kespiratory Hypoxemic Ph\_sician/ tailure disease or condition resulting in death) Medical Due to (or as a considuence of): Examiner Edem Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or injury signed by the attending physician and dbe detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 s, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Fibrillation 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan this certificate has perform 1 Yes 2 No 1 ☐ Yes 2 🔀 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 X No 은 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c License number D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towson, Md 21204 7601 Osler Drive Tat-Tee Khoo M.D. Francis

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Day 31 Month **Physician** WASIELEWSKI DECEMBER 2017 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) April 22,1933 Germany If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 XF 215-34-9035 78 **Director** Usual Residence of Decedent 10d. Inside City Limits or 28a-f show notified at 10b. County 10c. City, Town or Location 10a, State Dunda1k 1 ☐ Yes 2X No Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 6 Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. Examiner must be United States 21222 'natural", or items 23a 8047 Wallace Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2√XNo Specify Specify: White ş 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than Lever Brothers Company Line Worker 10 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amanda Schaflein Is marked Anton Weber ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8051 Wallace Road Dundalk, Maryland Mr. John Morrison (Friend) Health attem 27 l tem ; 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition permit. Pages 1 Department of H Important: If itel any Injury or otl 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland 1/4/2012 Parkwood Cemetery 5X Other (Specify)Entombment 4 Donation 21. Signatute of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Part 1. Enter the disease, or complications that caused the shock, or hear failure. List only one cause on each line. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Immediate Cause (Final PANCREATIL CANIER mmn **Physician** disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) NEUMON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner requires that the death certificate be executed that initiated events resulting in death) Last burial-trar and Due to (or as a consequence of) physician Box 68760, Physician/Medical the as nding p IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Tectopic pregnancy Year atten Month Day ρ in the past 12 months? 5 Other (specify) 2 X No be detached the Division of Vital Records, P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? 1 ☐ Yes 2 ☐ No 2**X** No certificate 25. Was case referred to medical 26. Place of Death Check onl one completely filled in by the funeral director, Be examiner? Hospital: 1 XInpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: After (Month, Day Year) Injury or Attending 1 Natural 5 Pending investigation 1 Tes 2 🗌 No death. 2 Accident after death 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide e Funeral I Hospital 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) within 2 To the F 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 11595 4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Warren Eugene Dvkes **Physician** 2ªy, December 2011 7:15 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Worcester Snow Hill Harrison Senior Living Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Country) MD Days 219-12-1309 XXM 2□F 89 09/13/1922 Director Usual Residence of Decedent 10b. County Wicomico 10c. City. Town or Location 10d. Inside City Limits . State ral", or items 23a or 28a-f show Examiner must be notified at Salisbury 1 Ves 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7604 Snow Hill Road 21804 by Funeral Pages 1 and 2 should be filed within 72 hours after death nert of Health and Mental Hygiene. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 ☐ Widowed 4 ☑ Divorced "natural", Year or Dates: al Hygiene. d other than "natura event, the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Communications 12 Communications other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unkn. unkn. f Health and Menta 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Bunker Hill Drive, Ruther Glen, VA 22546 Richard Warren Dykes / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/31/2011 Beltsville, MD Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Donota Marshall Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PROSTATE Immediate Cause (Final CANCER Physician METASTATIC resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to (or as a consequence of): Examine law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a □Yes 2□No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has all director, page 2 s autopsy pertorn 2No 1□ Yes 1 ☐ Yes To the Hospital or Attending Physician, within 24 hours after death.

To the Funeral Director: After this certific: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier ertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certified

31. Date filed (Month, Day, Year)

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JAN 0 4

SHARAU

1604 MARKET ST. POLOMOKE CITY MD SATYAL MI) e istrar's Signature

MI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month C DIGGS 16:51PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b City Town or Location of Death 4c. County of Death BALTIMORE BALTIMORE SAMARITAN HOSPITA 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖼 Months Hours Min (Month, Day, Director Usual Residence of Decedent items 23a or 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Xes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married and Mental Hygiene. is marked other than "natural", or Completed by 1 ☐ Yes 2 1 10 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State emetery, crema 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) more 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Death rain disease or condition Days Medical resulting in death) Examiner Ischemic morrhagic and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed ypertension and the burial-trar Due to (or as a consequence of) resulting in death) Last within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Day Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 3 Probably 4 Unknown 1 🗆 Yes Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? Yes 2 No 1 Tes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) RES OOD 12/25/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bal CHENGY 3 Registrar's Signature 31. Date filed (Month, Day, Year) State **JAN 0 4** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Joseph DeAngelis Lawrence 2011 Dec. 4:00 A Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Facility Name (# not institution, give a ros. 1351 South Clinton Street Apt. 222 N/A Baltimore City Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 213-42-3435 Director 1 🔀 M 2 🗆 F Maryland July 26,1944 67 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 1X Yes 2 No N/A Baltimore City MD 10e. Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? must be 23a Funeral United States 1351 South Clinton Street 222 Apt. items death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian the Medical Examiner Black, White, etc. 9 þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate 7 Years Real Estate Ith and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ and 2 should be Joseph DeAngelis Sadie Conavell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1351 S. Clinton Street Apt. 222 Baltimore, MD21224 Mrs. Harriette DeAngelis(Wife) t of Health other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 5 ☐ Burial 2X Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Hilltop Service Corp. 12/30/2011 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signat re f Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter ing disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Lancer. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir g physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical law requires that the death certificate be the attending IF FEMALE nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death detached 1 ☐ Yes ∠ ☐ Unknown g | Ilnknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be de Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an death? or Attending Physician: The latter death. 1 ☐ Yes 2 PNo 1 Yes 2 No this certificate the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 PNo Other: 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury Certificate: 28c. Injury at work? 28d. Describe how injury occurred after death. Director: After (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number filled in by determined building, etc. (Specify) City or Town, State) To the Hospital within 24 hours To the Funeral D Hospital Medical 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vele U LHAVIL JUBUME NIEN

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2011 whent /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number **Examiner** N/A Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 23,1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F Months Hours 84 Ohio 216-20-9806 **Director** Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c City Town or Location 10a State 10h Count 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 1 Tes 2 X No Dunda1k Director Baltimore MD 10g Citizen of What Country? 10e. Street and Number 10f. Zip-Code 1943 Denbury Drive United States 21222 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 □ No
If Yes, Give Black White etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No WWII Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Steel Industry Bricklayer 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) mit. Pages 1 and 2 should be fill partment of Health and Mental Hyportant: If item 27 Is marked othy Injury or other traumatic eventy Be Eugenia I. Gottschalk George W. Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Number of Rural Route Number, City or Town, State, Zip Code)

Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1943 Denbury Drive Dundalk, Maryland Mrs. Helen J. Edwards (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory or other place)
Holly Hill Mem. Gdns. 12/30/2011 HTX Burial 2 ☐ Cremation 3 ☐ Removal from State Middle River, MD permit. Page Department o Important: If i 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. uneral Service License 21. Signature AL 1 Rea 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, o shock, or heart a jure. List r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Fina **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ON Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) law requires that the death certificate be executed attending physician and d for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No page 2 should be detached for Pregnant at time of death 5 Other (specify) the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check onl one Be examiner? Hospital: 1 Inpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) \( \text{6} \( \text{Other (Specify)} \) 1 Yes 2 No 2 ER/Outpatient 3 DOA မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 1 X Natural 2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury 1 🗌 Yes 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CALETO dus GIORGIO 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) 32. Raistror's Signature

DHMH 17 Rev 1/2001 11595

State

Registrar

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 20a-c, per fh, 9923 1-17-12 sm #22 State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Angela M. Frank December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Thomas More Nursing Home Hyattsville Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9, Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funerai Hours Min (Month, Day, Year, Country 1 □ M 2 😾 F Director 1964 578-92-3678 47 Washington DC May Usual Residence of Decedent Show 10d, Inside City Limits 10a. State 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director 1 Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20032 3307 4th Street #B 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married þ 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: black 3 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16h Kind of Business Industry unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meany injury or other traumatic event, the Mean Elementary/Seconday (0-12) College (1-4 or 5+) 12 office clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Annie Pearl Frank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4016 23rd Pkwy #22 Temple Hills, MD 20748 Wanda Lilly/aunt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 1c Crematory 1/7/2012 Glen Burnie,MD Simplicity, Crem. & Fun. Service Thomas Affen P.A. 7090 Ridge Rd. Hanover, MD Baltimore, MD 21201 Atlantic Crematory 4 Donation 5 X One stat 21. Signature of Frineral Service L any in 23a. Part V. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, wheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. ANTERIOSCIEN Physician/ GREDIOVASCULAR DISCOS disease or condition resulting in death) eary Medical Due to (or as a consequence Examine Sequentially list conditions, Examine day, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year : www Pregnant at time of death 4 Pregnant 9 Unknown been signed by the should be detached 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cenebral (n fa notion labt Below Levec unjutation 1 Yes 2 No 3 Probably 4 Unknown Diabetes Millitres Peningrand arternal Disease 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performe End State Renal Disease / Dialys, & Covorany listery Disease 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide 24 hours after death. Funeral Director: A Investigation the 6 Could not be within 24 hours after des To the Funeral Directon completed filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 25 2011 01852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) security Rd Hyatterille Mil 2008 17 0 31. Date filed (Month, Day, Year) 82. Registrar's Signature State 4 2012 JAN 0 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Physician/ James Fahey atrick GSOPM Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Julianowoz Health Care washington Harenstow, If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 220-16-5963 Director 1 🕅 M 2 🗆 F Aug 6, 1926 85 Maryland Usual Residence of Dece or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 🗆 Yes 2 😾 No MD Washington Hagerstown 10e. Street and Numbe 10g. Citizen of What Country? Completed by Funeral 23a 21742 13105 Little Hayden Circle USA 1 and 2 should be filed within 72 hours after death 1 f Health and Mental Hygiene. item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status other traumatic event, the Medical Examiner Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify. white 3 Widowed 4 Divorced 44-46 Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+)  $1\overline{2}$ food service distributor hospitality Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Patrick James Fahey Regina Irene Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earlene Fahey/spouse 13105 Little Hayden Circle Hagerstown, MD 21742 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cramation 3 Removal from State 4 X Donation 5 Other (Specify) cemetery, crematory or other place) State Anatomy Board 655 W. Baltimore Street . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, wheart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ardiovascinar Albertosclerot disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transi Tensoion) and Due to (or as a consequence of): resulting in death) Last attending physician Dementia with Behavioral Districtance Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as the I IF FEMALE use es, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ jo in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 L Yes 2 L 9 D Unknown the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law Jas page 2 s autopsy performed? certificate ! 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital ည 1 Inpatient 2 ER/Outpatient 3 DOA After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred ⋈ Natural iniurv 5 Pending death. 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Barbara

State Registrar PRNP-333 MILL Stoept, Hagerstown, MD 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1 Decedent's Name (First Middle Last) 2. Date of Death Day Physician/ Joan Criel Ferguson December 9:00 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital N/A Baltimore City . Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Hours Director 068-26-8335 1 M 2 X F Yrs. 78 Feb. 16,1933 New York 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Glen Arm Baltimore 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 11630 Glen Arm Road 21057 Apt. L 25 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: "natural", If Yes, Give 3√X Widowed 4 □ Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Health Care Provider life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Years Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Edmond Crie1 Margaret Sullivan 19a. Informant's Name/Relationship (Type, Print)Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 stiment of Health a tant; If item 27 i Jennifer McNary Smith 1904 Haverhill Road Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of I 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) injury or 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 12/28/2011 Towson, Maryland any in Signature of Funeral Service Licenses Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland Wise Ave Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ 1112 201/11/12 disease or condition unKnoevin Medical resulting in death) Examiner unknown Sequentially list conditions Examine if any, leading to in medicause. Enter Underlying Cause (Disease or injury that initiated events consequence of) unknown or Attending Physician: The law requires that the death certificate be executed chan onoug duse as & the burial-tran and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical unklieun ONOV Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death No be detached Unknown g 🔲 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 1 No Other: ၉ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Man or of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29d. Date signed (Month, Day, Year) DO064788 MI 1) ecember 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE SUITE 301 SMA 2120 31. Date filed (Month, Day, ¥ear) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Harriet Flotte 5:26 P M 2011 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Joseph Medical Center Baltimore Towson Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 180-24-2410 7/13/1924 Pennsylvania Director 1 🗆 M 2 🔽 F 87 shov 10c. City, Town or Location 10d. Inside City Limits must be notified at Completed by Funeral Director 28a-f 1 Yes 2 No Maryland Baltimore Towson ò 10f. Zip Code 10g. Citizen of What Country? 23a 21286 540 Hampton Lane U.S.A. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Shand Harriet Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1118 Shumway Court Faribault, Minnesota 55021 Tom Flotte / Son 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1/2/2012 Hilltop Serv. Corp. Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Pulmonary Hemorrhage disease or condition 30minuted Medical resulting in death) Examiner STENOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or injury that initiated events resulting in death) Last monar nding physician Cardiovascular Disease Physician/Medical that the death certificate be evetic Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day signed by the aid be detached for 1 Yes 2 D
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy 1 ☐ Yes 2 No ☐ Yes 2 X No eral Director: After this certificatiled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hew To the Hospital or Attending 1 Natural 2 Accident 3 Suicide 5 Pending injury 12/28/2011 5:00 KM 1 Yes 2 No during cardiac Cath Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory office building, etc. (Specify) 28f. Location eet and Number 4 Homicide determined City or Town, State, within 24 hours a To the Funeral C Towson Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of c eath (Item 3a) (Type, Print) TRIMBLE HILL CT. Lutheru: [] MILITELLO State Registrar

Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible. Katherine Fleming State of Maryland / Department of Health and Mental Hygiene 2011 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Medical Examiner Fleming 1545 hrs Katherine December 26, 2011 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Maryland General Hospital **Baltimore** N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 218-21-6780 March 16,1988 23 1 M M 2X F Country) MD Yrs Usual Residence of Decedent iny 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2X No MD Baltimore Essex permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-5 she injury or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 Maryland Avenue 21221 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 X Never Married 2 Married White, etc. 2 X No Yes 3 Widowed Yes, Give Year 4 Divorced 1 Yes 2 X No specify: Specify: White ò 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ltimore, MD 21215-0036 10 Years Dependant N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franklin Fleming, Jr. Pauline Otto 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 Maryland Avenue Baltimore, Maryland Franklin Fleming, Jr. (Father) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corp 12/29/2011 Towson, Maryland 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Inc. 21222 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Cocaine and narcotic intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last ned by the attending physician and detached for use as the burial - transi Physician/Medical UNPENDED AMENDED 23a, 27, 28a-f, per ME g923 1/27/12 TRT To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After the certificate be to the Funeral Director: IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ই 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been if funeral director, page 2 should 24a, Wes an 24b. Were autopsy findings available prior to completion of cause of eutopsy performed? death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other: 1 🗸 Yes 27. Manner of Deeth 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural neral Director: , filled in by the fi 5 Pending Fd 12/25/11 Fd 0818 hrs 1 Yes 2X No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3024 Auchentrolley Ter. Baltimore, MD 3 Suicide 6 X Could not be determined 4 (Specify) residence Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated. (Che one) 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 28, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G923 1/06/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:31 AM Physician/ Medical institution, give street and numbe Location of Death 4c. County of Death **Examiner** Bru 0 8. Date of Birth (Month, Day, last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 1 🗆 M 2 🔀 F Director Yrs. 26 28a-f show 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location notified at Funeral Director 1 Yes 2 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a or edical Examiner must be 21213 enyon 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working file. DO NO case retired) 15. Decedent's Education (Specify only highest grade completed) ty Yubla more ndary (0-12) College (1-4 or 5+) To Be Eather's Name (First, Middle elationship (Type Balto Lombard Date **161** Method of Disposition Place of Disposition (Name of ity or Town. State 1 Burial 2 Cremation 3 Removal from State cemetery, cremator r other place) 4 ☐ Donation 5 ☐ Other (Specify) Votre and Add ene 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ und ancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or injury that initiated events the attending physician and thed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death been signed by the a should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No After this certificate has page 2 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 FR/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Investigation work? 2 🗌 No Accident within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in, my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature hd title of certifier 29d. Date signed (Month, Day, Year) oll completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Day 32. Registrar's Signature State 4 2012 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 1150 AM Robert E. Gee DECEMB 28201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** AGNES HOSPITAL TIMOR . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Hours Min. (Month, Day, Year) 215-28-6848 78 Director Usual Residence of Decedent or 28a-f shov notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d, Inside City Limits Funeral Director MD NA Baltimore XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #906 item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 1600 W. Mt. Royal Avenue Apt 21217 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?

1X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. African Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: American 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cement Finisher Laborer 8th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Samue1 Gee Mattie Crawlev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilhelmenia Gee-Wife 1600 W. Mt. Royal Avenue Apt. #906 Balto; MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cem. 01-05-12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. 638 Gilmor Street Baltimore.MD 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final nset and ath Physician. disease or condition resulting in death) Medical Due to (or so a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death been signed by the a should be detached i 1 ☐ Yes 2vg 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires t ivision of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has perform funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 2 1 Yes Inpatient 2 - ER/Outpatient 3 - DOA Date of injury (Month, Day, Year) 27. Manner of Death Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending
Investigation work? 1 ☐ Yes 2 ☐ No. Accident within 24 hours after death To the Funeral Director Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) JAN 0 4 2012

DHMH 17 Rev 7/2009

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 12:51 PM December Medical <u>Joan Grace Grav</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford 2010 Carsins Run Road Aberdeen 5. Social Security Number 8. Date of Birth
Oct. 20, 1939 g. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 D M 2 1 F Months Days Hours **Director** 213-36-1025 72 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10h County 10a, State 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2010 Carsins Run Road 21001 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Hygiene. other than "natural", or i Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Irene Margaret Caroline Winkler <u>Henry Leonard Tremper</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Andrew Court, Aberdeen, Maryland 21001 <u>Cynthia Van Seeters / Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn. 1/4/2012 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1314 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or co. p c shock, or heart failure. List only one ca ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ u/monasy disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) death certificate be executed ex tremity Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 1 Yes 2 g signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pothyReidism Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical **Division of Vital** funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 Yes 2 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 🔼 Natural 5  $\square$  Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ determined filled in Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 602 5. Atwood Rd # 207 B21 And M) 21014 Hara panahalli

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year) JAN 0 4 2012

32. Registrar's Signature

Physician/ Medical **Examiner** 28a-f shov with the Maryland death Maryland 21215-0036 within 72 hours after Baltimore, DECEMBER

6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** (Month, Day, Year) Hours Min Director 1 M 2 X F 214-14-8086 Yrs. 1921 Aug. 7, 90 Usual Residence of Deced 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Maryland Harford Abingdon 10f. Zip Code 10e. Street and Numbe Funeral 3202 Wilson Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. by 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 's my injury or other traumatic event, the Meany injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Telephone Operator 10 Be 17. Father's Name (First, Middle, Last) 0 Emily (nmn) Keene Gottfried (nmn) Egli 19a. Informant's Name/Relationship (Type, Print) 3202 Wilson Ave., Abingdon, Debbie Wigfield / Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 12/29/11 Meadowridge Mem. Pk. 4 Donation 5 Other (Specify) 2. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, of uneral Serv 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ END STAGE DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Physician/Medical Examiner Due to for as a contequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last been signed by the attending physician To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 X No GERWIG 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 1 Tes 24a. Was an autopsy Director: After this certificate has Yes 2 X No director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at injury 5 Pending X Natural work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours Medical 29a. Certifier 29b. Signature and title 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 CRNP 2300 DULANEY VALLEY RD. JACKIE JONES, 31. Date filed (Month, Day, Yea 32. Registrar's Signatur State 4 2012 Parks Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2011 Lucia Frieda Gerwig 10:30 A December 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? 14. Race - American Indian. Black, White, etc. Specify: White 16b. Kind of Business/Industry Communications 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21009 20c. Location - City or Town, State Baltimore, Maryland MD 21009 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 No 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Courcil Hughley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

**UNK UNK** 2011 42185 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day December 12, 2011 **Medical Examiner** 1316 hrs COuncil Hughley 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 612 N. Montford Avenue **Baltimore** 5. Social Security Number 1117 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** unk Foreign Country) Min. Months Davs Hours Director Mar 24, 1X M 71 2\_\_\_F Yrs 1940 Usual Residence of Decedent 10a. State 10b, County 10c. City, Town or Location 10d, Inside City Limits 1 Yes 2 No MD Baltimore death with the Maryland Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 612 N. Montford Avenue 21205 USA Funeral 12. Was Decedent Ever in Usin k 11. Marital Status 13. Was Decedent of Hispanic Drigin? (Specify Yes or Nounk 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married White, etc. 2 Married Yes Pages 1 and 2 should be filed within 72 hours after of thealth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner in 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: black ≦ 16a. Decedent's Usual Dccupation (Give kind of work done unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed unk during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 unk unk 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 W. Baltimore Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other Specify: 21. Sig a see of Funeral S ige Licens <sup>22</sup> State Anatomy Board 655 W. Baltimore Street Director Baltimore MI) 21201
ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and /Medical Death a. Narcotic (Morphine) Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g923 1-12-12 sm attending physician a X UNPENDED P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery edent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Dther (Specify) Jo 1 Yes 2 No 9 Unknown Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed Division of Vital Records, To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other; Scene 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification Natural 5 Pending 1 Yes 2 X No unknown fd 12-12-11 fd 1:16 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 612 N. Monford Ave. Baltimore, Md. 3 Suicide 6 X Could not be within 24 hours a determined (Specify) Found in vacant house 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 13, 2011 M 30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month HAWS\_-DIXON  $\mathbf{P}_{\mathsf{M}}$ 7:20 **GLORIA GRAHAM DECEMBER** 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CHARLES 5310 HALIBUT PLACE WALDORF Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth 1 M 2 XF Months Hours Min (Month, Day, Year) 8-29-1952 266-11-5272 FLORIDA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. CHARLES WALDORF 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5310 HALIBUT PLACE 20603 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, med Forces? PERSIAN Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give—GULF WAR Year or Dates. 1 ☐ Yes 2 ☐XNo Specify: 3 Widowed 4 Divorced Specify. BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) RETIRED\_NURSE HEALTHCARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LONNY O. GRAHAM SR. DORETHA HILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOESEPHUS DIXON(HUSBAND) 5310 HALIBUT PLACE WALDORF, MARYLAND 20603 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, FLORIDA NATIONAL CEM. 1-4-2012 BUSHNELL, FLORIDA Signatu uneral Service Licensee JQNATH M HIBNH R2. Name and Address of Facility MITCHELL S FUNERAL HOME 501 FAIRVILLA RD. ORLANDO, FLORIDA 32808 ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, br heart failure. List only one cause on each line. 23a. Part 1 shock Immediate Lause (Final Onset and Death METASTATIC BREAST CANCER disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 XUnknown . Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 ☐ Yes 2 ☐ No Yes 2 X No

Physician/ Medical **Examiner** 

Physician/

Medical

**Examiner** 

**Funeral** 

Director

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28a-f

ms 23a or must be r ŏ

Examiner

items

al Hygiene. d other than "natura event, the Medical E

permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin

Maryland 21215-0036

Baltimore,

notified at

rector

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Funeral

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Completed

Be

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the Maryland

burial-transit attending physician for use as the burial Division of Vital Records, P.O. Box 68760 the

page 2 certificate funeral director, within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director.

To the Hospital or Attending Physician:

Physician/Medical þ Completed 25. Was case referred to medica Be ၉ 27. Manner of Death Certificate:

Medical

examiner?

1 Yes

Natural

Suicide

4 Homicide

29a. Certifier

Accident

2 **X** No

5 Pending

determined

Examir

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of injury Investigation 6 Could not be

28c. Injury at work?

1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MD# 33255

Other:

26. Place of Death (Check only one)

4 Nursing Home 5 X Residence 6 Other (Specify,

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

JANUARY 3, 2012

28f. Location (Street and Number or Rural Route Number, City or Town, State)

of death (Item 23a) (Type, Print)
D. VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688 O. Name and address of person who completed cause of de KAREN ANN BLACKSTONE, M.D.

31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4:20A M 2011 Hollev Cassandra Dec Tvra Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Center Towson Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours Min. 11-18-76 Country MD 212-88-35 24 35 **Director** 1 □ M 2 🏲 F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location notified at Director 28a-f 1X Yes 2 No Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or must be r Funeral USA 21206 5416 Summerfield Avenue items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status er than "natural", or ite the Medical Examiner Armed Forces?

1 Yes 2 XNo Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. African þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: American 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me once. M & E Construction Co. College (1-4 or 5+) Elementary/Secondary (0-12) GED ŇΑ Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Holley Doreen Donald Holley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 904 Radcliffe Road Towson, Maryland 21204 Janice Sneed-Cousin Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Randallstown, Mem. Pk. 12-31-11 King 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. Street Baltimore, MD 21217 638 N. Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anns Physician/ 12-5 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed the burial-trar attending physician and I for use as the burial-trai Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day Month Pregnant at time of death 5 Other (specify) the 9 Unknown s been signed by t ? should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ⚠No 24a. Was an has page 2 autopsy certificate 25. Was case referred to medical filled in by the funeral director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 L Yes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu and title of certifier 29d. Date signed (Month, Day, Year) ress of person who completed cause of death (Item 23a) (Type, Print) HARLIRS 32. Registrar's Signatur

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Marylar					ental Hyg	iene		1 0	100		
		-	1 - State Registrar Certificate of Death Reg. No. 20 4 2 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De									188		
Г	Physicia		Richard K.C. Hsieh				,	Decembe:						
Mariner	Medic Examin		4a. Facility Name (if not institution, give street and number)	n of Death	eath 4c. County of Death									
	Farmanal		601 Stacy Court Towson  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I funder 24 Hrs. 8. Date							Baltimore  tte of Birth 9. Birthplace (State or Foreign				
b	Funeral Director		219-34-1082 1 x M 2 D F 79	Yrs.		ays Hours	Min.	(Month, Day,		Coun	ntry)	or orgri		
	id now	Ļ	Usual Residence of Decedent	ty, Town or Loc	cation		,	June 7,	1932		ina 10d. Inside City	Limits		
	arylar la-f sh ified a	ecto		wson	oution						1 🗆 Yes			
	the M	١	10e. Street and Number		10f. Zip Cod	de		1	0g. Citizen of V					
	h with	Funeral Director	601 Stacy Court		212					USA				
10	r deat or iten niner r	by Fu	11. Marital Status  1 □ Never Married 2 ☑ Married  12. Was Decedent Ever in U.s Armed Forces?  1 □ Yes 2 ☒ No	S. 13. V	Vas Decedent of Yes, specify C	of Hispanic C Cuban, Mexic	origin? (Spec an, Puerto F	ify Yes or No- lican, etc.)		e - Amerio k, White,	can Indian, etc.			
21215-0036	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ed b	3 Widowed 4 Divorced Year or Dates.	1	Yes 2 🔀	No Specia	fy:		Specify:	Asi	an			
5-0	2 hou "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	dent's Usual Oc kind of work do	ne during mo	ost of workin	g	16b. Kind of B	usiness/In	dustry			
121	led within 72 Hygiene. <b>other than '</b> ent, the Me	Con	Elementary/Secondary (0-12)  College (1-4 or 5+) 5+		o notuse retii c Healt		7.		Feder	al G	overnme	ent		
	z → <b>£ t</b>	Be	17. Father's Name (First, Middle, Last)			18. Mo	ther's Name	(First, Middle, N	aiden Surname	<b>a</b> )				
ylaı	should be file n and Mental h 7 is marked o raumatic eve	욘	Hui Hsieh			AJ	lice	Cheng						
Maryland	age 1 and 2 should be file int of Health and Mental I t: If item 27 is marked o 7 or other traumatic eve		19a. Informant's Name/Relationship (Type, Print)  Rebecca Hsieh/ Wife	11	ng Address (Str Stacy C			Route Number,	-	tate, Zip (	Code)			
re,	ge 1 and 2 s at of Health of Health or other tra		20a. Method of Disposition 20b. F	Place of Dispos	sition (Name of	f !			20c. Location -	City or To	own, State			
imo	Page ment c ant: If ury or		1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crem	service	Co.	1-3-1	2	Towsor	ı, MD				
Baltimore,	permit. Page 1 Department of Important: If i any injury or once.		21. Si paya, o'll-un val Syvic i Li ensee	22	. Name and As	dress of Fac UCK TO	owson ork Rd	Funeral . Towso	Home,	Inc.	4			
			23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	th. Do not ente	er the mode of	dying, such a	as cardiac or	respiratory arre	st,		Approximate Interval Betw			
~	Ph_sician/		Immediate Cause (Final disease or condition	-dash	- SV	ndro	me				Onset and De			
	Medical Examiner		resulting in death)  Dueto (or as a conjequ	uer ce of):										
		ner	if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of the constant of the const	uence of):						+				
	outed nd transit	Examine	Cause (Disease or injury that initiated events c.							$\perp$				
	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical E	resulting in death) Last Due to (or as a consequ	uence of):										
760	icate b physi is the b	ledic	d							$\pm$				
(687	ending r use a	an/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Feta	ancy	Ectopic pregr	nancy			23d. Da	te of deliv	rery			
Вох	death the att	Physician/Me	in the past 12 months?  1 Yes 2 No 4 Pregnant at time of 6 9 Unknown		Other (specif)				Mo	nth	Day Ye	ar		
P.O.	hat the ed by i detacl		Part II. Other significant conditions contributing to death but not res	sulting in the u	nderlying caus	e given in Pa	rt I.	23e. Did tob	acco use contr	ribute to t	he cause of de	ath?		
ls, l	uires t n sign uld be	ed by	Renal Insufficiency					1 □ Y€	s 2 No	3 🗌 Pro	bably 4 🗌 U	nknown		
cor	law rec has bee ge 2 sho	Completed	Diabetes					24a. Was ar		Nere auto	ppsy findings av	ailable use of		
Be	: The la cate ha r, page							perform	ned?	death?	2 🗆 No			
/ital	sician: The certificate lirector, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2  No Hospital:			Other:	'		о П он	(0 )				
of \	ig Phys ter this neral di	te: To	27. Manper of Death 28a. Date of injury	28b. Time of injury	28c. l	njury at		ne 5 🗹 Reside 8d. Describe ho			/)			
on	tendin leath. or: Aft the fu	Certificate:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	injury		vork?	□ No							
Division of Vital Records,	l or At after d Direct d in by	Cert	4 Homicide determined 28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory, offi	ce	2	8f. Location (Sti City or Town		∍r or Rura	l Route Numbe	r,		
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p. completely filled in by the funeral director, page 2 should be detached for use as t.	Medical	29a. Certifier 1 Certifying Physician: To the best of my know (Check 2 Medical Examiner; On the basis of examination									ner stated		
	o the Frithin 24 orthe Fromplet	Me	only one) 3 Certifying Nurse Practitioner: To the best of r		death occurred		date and plac	e, and due to the		nanner as	stated.			
	In an		Deffrey Sonce Magazine	MD	-	1	944		Tanuar	Y .	3, 20	2		
	10 %		30. Name and address of person who completed cause of death (Item	23a) (Type, P	rint)	- 81	11	dage 1	1 MM	1	21022			
	Stat		31. Date filed (Month, Day, Year) 32. Jegerrar's Signar	tur	2 ( 9)	is Rd.	/	MAKALI	14	2	1007	-		
	Registra	ir	IAN 0 4 2012 / Duna	a. 190	Charles and the same of the sa									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 42189 Certificate of Death Rea. No. Decedent's Name (First, Middle, Last)
Harvey Hartstall 2. Date of Death 3. Time of Death Physician/ 2.30 A M 12/18/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8500 16th Street #112 Montgomery Silver Springs 5. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours unk 1 XM 2 □ F **Director** 69 05/07/1942 Wash D.C. 28a-f shov 10d. Inside City Limits with the Maryland 10a, State 10b. Count 10c. City, Town or Location the Medical Examiner must be notified at rector Silver Springs MD Montgomery 1 ☐ Yes 2X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 8500 16th Street #112 20910 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 'natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic mans. Elementary/Secondary (0-12) College (1-4 or 5+) Unk Unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Derwin Hartstall Sarah Busch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7760 Painted Sunset Dr. Las Vegas NV 89149 Deborah Elana Master Niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Judean Gardens 12/28/11 Olney MD 4 Donation 5 Other (Specify) funeral Service License 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Immediate Cause (Final .Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death the 2 No Yes signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 42 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital မ 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No within 24 hours after death

To the Funeral Director: ∠
completely filled in by the t Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of cer 29c. License number

State Registrar WA DWE

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30. Name and address of person who completed caose of death (Item 23a) (Type, Print)

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Virginia Marie Hartley Physician/ 2011 11:11 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Catonsville Baltimore 1208 Keithmont Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 220-44-7750 82 **Director** 1 □ M 2 🕱 F Sept. 4, 1929 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits with the Maryland aţ 10a. State 10b. County 10c. City, Town or Location Director notified 1 Yes 2 X No MD Baltimore Catonsville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō ral", or items 23a or Examiner must be r Funeral USA 1208 Keithmont Road 21228 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, 1 Never Married 2 Married þ White Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event \*\*\*\*\*. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) St. Mark School Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Rosa M. Horn Frank A. Feild 19a. Informant's Name/Relationship (*Type, Prin***Husband** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1208 Keithmont Road; Catonsville, MD 21228 Brent A. Hartley -Father 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State competers, crematory or other place)
Loudon Park Cemetery 1/6/2012 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue; Catonsville, MD 21228 M01050 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Approximate inte al Between
On t and De Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atte in the past 12 months? Month Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Waknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 s has certificate 1 Yes 2 No 1 Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 KNo ည 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending ours after death.

eral Director: Aff
filled in by the fu 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature address of person who completed cause of death (Item 23a) (Type, Print) SALTIMONE 31. Date filed (Month, Day, Year 32. Registrar's Sinature State JAN 0 4 Registrar

Physician/ Medical Examiner

> **Funeral** Director

> > any

irector

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Funeral

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Completed

Be ဥ

other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once.

permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 22a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical

Examiner

Baltimore, MD 21215-0036

2

ert I- For State	State of Maryla			f Health and Mer f <i>Death</i>	ntai Hy		eg. No.	201	1 421	
Registrar 1. Decedent's Name (First Richard Will					2	Date of Dea Month Decembe	th	Year	3. Time of Death 1137 hrs	
	stitution, give street and nu	mber)		4b. City, Town, or Location	of Death	Decembe		nty of Deatl	1	
5338 Grovemont	Drive			Elkridge			Howa			
5. Social Security Number 230-08-3357	6. Sex	7. Age (In yrs, last b	rthday) Yrs	Months Days Hour	ler 24Hrs.	8. Date of Bir June 8		Forei	thplace (State or gn puntry) Virginia	
Jsual Residence of Decei		10c. City. Tow	n az l agot	ion					10d. Inside City Limit	
	ounty Howard		ridge	lon					1 Yes 2 XX	
Oe. Street and Number				10f. Zip Code			0g. Citizen of	What Cou	ntry?	
5338 Grovemon	t Drive			21075		l'		J.S.A.	,	
1. Marital Status		edent Ever in U.S.		as Decedent of Hispanic Or es, specify Cuban, Mexical				ace - Amer	ican Indian, Black,	
1 Never Married 2	1 Yes	2 X No				icari, e.c.)			<b>.</b>	
3 Widowed 4	Divorced If Yes, Give Year or Dates:		1	Yes 2 X No specify			Speci			
	n (Specify only highest grad (0-12) College (1			nt's Usual Occupation (Givenost of working life. DO NO			16b. Kind o	Business/	Industry	
Elementary/Secondary	(0-12) College (1	-4 or 5+)	Owne	or.			Swim	ning Po	กใร	
7. Father's Name (First,	Middle Last)	L	OWIR		er's Name (I	(First, Middle, Maiden Surname)				
Glenn Willia				1		Barbara				
9a. Informant's Name/Re	lationship (Type, Print )	1	9b. Mailin	g Address (Street and Nu				Fown, State	e, Zip Code)	
Amy Hilbert	(Wife)	- 1	5338 (	Grovemont Drive	E1kri	dge, Mai	ryland 2	21075		
0a. Method of Disposition				sition (Name of cemetery,		Date	20c. Locati	on - City or	Town, State	
-	emation 3 Removal fro	JIII State	-	herplace) rematory	1-2-2	012	Glen E	Burnie.	Maryland	
4 Donation 5 O 1. Signature of Funeral S				Name and Address of Facili						
23a Part I. Enter the dise	ase, or complications that ca	aused the death. Do							Approximate Interv	
failure. List only one	cause on each line.			and Cocaine 1					Between Onset an Death	
mmediate Cause (Final d or condition resulting in d		consequence of):	1011	and obcurre					1	
Sequentially list condition if any, leading to immedia		consequence of):								
Chisease or injury that initiated										
events resulting in death)		consequence of):								
X UNPENDED		3a,27,28a	-f,pe	er me,g923 1-	-20-12	2 sm				
F FEMALE: 3b. Was decedent pregna past 12 months?  1 Yes 2 No 9	ant in the 1 Live b	ant at time of death	2 Fe	etal death 3 Ectop	ic pregnan	су	23d. Dat Mont	e of deliver	y Day Year	
	_ 9 _ Unkild		:_ Ab	and in a second above to F	) and I	230 Did to	shaces use o	antributa to	the cause of death?	
Part II. Other significant	contributing to	ueam but not result	ng in the t	underlying cause given in P	atti.				bably 4 Unknown	
			-			24a. Was			utopsy findings availab completion of cause of	
				<del></del>			rmed?	death?		
5. Was case referred to	medical			26.Place of Death	(Check or		Z NO	1 V 1	2 140	
examiner?	[Hospital:	notiont 2 5	Outpetie	Other: 5		,	Residence	6 104-	r. Scono	
1 <b>✓</b> Yes 2 1		npatient 2 ER/	Outpatient	3 DOA 001814	raursing	Home 5	residence	O THE	i. Godine	

Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial - transi Physician/Medical Division of Vital Records, P.O. Box 68760, Š Completed After this certificate has been funeral director, page 2 should Be Certification: within 24 hours after death.

To the Funeral Director:
completely filled in by the f Medical

25. Was ca 1 🗸 27. Manner of De . Date of Injury (Month, Day,Year) Natural 1 Yes 2 X No unknown

5 Pending fd 12-29-11 fd 11:30 am Investigation Accident 6 X Could not be 3 Suicide determined Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) residence

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner\_stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E

900 W. Baltimore Street, Baltimore, MD 21223

28f. Location (Street and Number or Rural Route Number, City or Town, State) **5338 Grovemont Dr** 

December 30, 2011

Elkridge, MD.

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD Assistant Medical Examiner

OCME

31. Date filed (Month, Day Year) JAN () 4 2012 State Registrar

32. Registrar's Senature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2011 42		9	١,
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		i- For State Registrar	Certifi	cate of E	Peath		R	2 U I eg. No.	1 4213		
Physiciar	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year						3. Time of Death 0715 hrs				
Medical Examin		Fidel Ali Holmes  4a. Facility Name (if not institution, give street and number)	5	I <sub>4</sub> h	City Town or	Location of		der 30, 2011 07131113			
1		3630 East Fayette Street	_	E	Baltimore						
Funeral Director		5. Social Security Number 671-58-3489 6. Sex 12 F 7. Age (In yrs. last birthday) 12 F 7. Age (In yrs. last birthday) 15 F 7. Age (In yrs.							gn		
any .		Usual Residence of Decedent           10a. State         10b. County         1		vn or Location					10d. Inside City Limits		
	5	MD	Bal	timore	9				1 X Yes 2 No		
th the Maryland 23a or 28a-f sho notified at once	e E	10e. Street and Number 3630 E. Fayette St.		1	Of. Zip Code 2122	Og. Citizen of What Cou USA	intry?				
leath wi	Funeral	11. Marital Status  1 X Never Married  2 Married  Armed Forces?  1 Yes 2 X  3 Widowed  4 Divorced If Yes, Give Year	ver in U.S.	If Yes,	specify Cuban	, Mexican, I	n? ( Specify Yes or No Puerto Rican, etc.)	14. Race - Ame White, etc.  Specify: B1	rican Indian, Black,		
urs afte	호	15. Decedent's Education (Specify only highest grade comp	oleted) 16a	1 Yea. Decedent's	X_	specify: ion (Give ki	ind of work done	16b. Kind of Business			
11215-0036 Id be filed within 72 hours are femal Hygene. narked other than "natural event, the Medical Examine Femal Column 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Completed	Elementary/Secondary (0-12) College (1-4 or 5+	+)	during most	of working life.	DO NOT u	use retired)				
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	틹	none		none				none			
ID 21215-003 should be filed withi and Mental Hygiene. 7 is marked other the natic event, the Med		17. Father's Name (First, Middle, Last)  Eugene Holmes					Name (First, Middle, ra Green	Maiden Surname)			
2121 2121 Duld be fil Mental I marked ic event,	lo Be	19a. Informant's Name/Relationship (Type, Print )	11	19b. Mailing A	ddress (Street			nber, City or Town, Stat	e, Zip Code)		
and 2 shou lealth and N	1	Kiara Green (mother)	1:	3630 I	E. Fay	ette	St. Bal	to,Md.212	24		
ore, ME is 1 and 2 s of Health ar of Health ar of traum.	Ī	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State		e of Dispositio atory or other	n (Name of cen place)	netery,	Date	20c. Location - City o	Town, State		
Pages nent o	-	4 Donation 5 Other Specify:	Mt.	Carme	L Ceme	tery	Jan.6,2	12 Balto	,Md.		
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum	1	21 Signature of Funeral Service Licensee		I Cal	ne and Address LVIN B	.Scr	uggs Fun	eral Home			
Physician	+	23a. Part I. Enter the disease, or complications that caused the	ne death. Do	not enter the	node of dying,	Presisuch as car	ton St rdiac or respiratory an	Balto, Md est, shock, or heart	21213 Approximate Interval		
(Medical	1	failure. List only one cause on each line.  Immediate Cause (Final disease a. Sudden Inf							Between Onset and Death		
£xaminer		or condition resulting in death)  Due to (or as a consequence)		Juli D	marome						
	힐	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause	quence of):								
**	티	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence)	juence of):								
ecuted and - transit		d.  TX UNPENDED AMENDED 23a	27 20		024 2-2	22_12	C.T.				
60, cate be ex physician he burial	Medical				, J Z 4 Z – Z	22-12	ъш	23d Date of deliver			
K 6876  1 certificat ending ph use as the	Provided the second state of the second state						y Day Year				
Box 68: death certiff the attending of for use as	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	me of death	5 Other	(Specify)				-		
O. B. at the de lby the tached f		Part II. Other significant conditions contributing to death	but not result	ing in the und	erlying cause g	iven in Part	t I. 23e. Did t	obacco use contribute to	the cause of death?		
ires that to signed by the detact	ğ o							s 2 No 3 Pro	bably 4 Unknown		
cords law requi	Completed			<u>-</u>			24a. Was	osy prior to	utopsy findings available completion of cause of		
Rec The Is icate h	틹						1 ✓ Yes	rmed? death? 2 No 1 ✓ Y	es 2 No		
tal Recician: The certificate rector, page	8	25. Was case referred to medical examiner? [Hospital: 1 ] Inpatient					Check only one)  Nursing Home 5				
Phys r Phys rer this eral di	의	1 Yes 2 No 28a. Date of Injury	/ 288	Outpatient 3		y at Work?		Residence 6  Othe	r: Scene		
on on canding arth.	[	1 X Natural 5 Pending (Month, Day, Yea	ar)		1 T	es 2 🗌 l	No				
Division of Vital Records, P.O. Box 68760,  Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and the filled in by the funeral director, page 2 should be detached for use as the burial - transfer.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	ıry - At home,	farm, street, f	actory, office b	uilding, etc.	. 28f. Location ( or Town, \$	Street and Number or R State)	ural Route Number, City		
Division  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	ल	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.									
H S H O	Ĭ	29b. Signature and title of certifier	200		29c. License			29d. Date signed (Mo			
(2)		Joelo Station fell	-45 /#= :: ==		0.C.N	VI.⊏.		December 31, 2	011		
		30. Name and address of person who completed cause of dea Victor Weedn MD JD Assistant Medical B	- '	•	Baltimore S	treet, Ba	Iltimore, MD 212	23			
Stat Registra	-	31. Date filed (Month, Day, Year)  32 Registrar's	s Signature	back	,						
DHMH 17 Rev 1/200		OGME	0	RIGINAL				<del></del>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Juda Month Physician/ 17:30 31,2611 Deelmber Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Hopkins Year If Under 24 Hrs. 9. Birthplace (State or Foreign (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Min (Month, Day, Year, Director 1 **X**M 2 □ F 62 2-22-1949 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 No timore 0 Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral auste . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1. Marital Status Never Married 2 Married or Completed by 1 Yes No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. /Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship குற 19b. Mailing Address (Street and Number or Rura Route N ber, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place ₩ Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2017 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of of such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Ph, sician metastatic cancer Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence oi). and Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day been signed by the s should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 After this certificate 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, eral Director: After thi filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 24 hours Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within 2 To the 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

State

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sopnie wells

31. Date filed (Month, Day, Year)

600

32. Registrar's Signature

North

Battimore mD 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7 Per FH G923 1/17/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) DECOMBER Physician/ 2.308M 30 2011 RUSSELL LEWIS\_JOHNS Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner HISPITAL OF BALTIMORE BALTIMORE N/A 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 6-8-1925 9. Birthplace (State or Foreign **Funeral** 212-20-5283 85 86 yrs MARYLAND Director 1 **▼** M 2 □ F 28a-f show 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location Director must be notified N/A BALTIMORE 1 XYes 2 No MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ь items 23a Funeral USA 1209 N. GILMORE ST. 21217 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married "natural", or þ Specify: BLACK 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene Important: If item 27 is marked other than " any injury or other traumatic event, the Meione. Elementary/Secondary (0-12) College (1-4 or 5+) SOCIAL SECURITY INSTRUCTOR Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ ANNIE LEWIS IRVIN JOHNS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1209 N. GILMORE ST. BALTIMORE, MARYLAND 21217 JANET JOHNS (WIFE) 20a. Method of Disposition 1 ☑ Burial /2 ☐ Gren 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 2 Cremation 3 Removal from State ARBUTUS MEMORIAL PARK 1-9-2012 BALTIMORE, MARYLAND 4 Donation 5 D Other (Specify) Funeral Servive Licenses ONATMAN D. HIBNI R22. Name and Address of FacilitREDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part II Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset nd Death HEART Immediate Cause (Final Ph sician/ CONGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Day Month Pregnant at time of death Unknown 1 ☐ Yes 2 **>** 9 ☐ Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ALTELY DISTAGE 1 Yes 2 No 3 Probably 4 Vinknown Completed . Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No FIBRILLATION 24a Was an autopsy performed? าสร 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 [ 29d. Date signed (Month, Day, Year) 29b. Signature and tie of certifier 00072030 DOGEMBER, 30, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUSPITAL OF BALTMORE, 240 W. BAVERENE AVE, BALTMORE, 2125 PUSHAPDLEP KBRAR. SIDIBI State Registrar

2USSEL1

OHNS,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 16, 2011 December 5:40 Joyce Virginia Kratz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Marley Neck Health & Rehab Glen Burnie Anne Arundel 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Director 241-46-5495 75 1 🗆 M 2 🗶 F Oct.14, 1936 North Carolina Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Pasadena Anne Arundel Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
USA by Funeral 21122 114 Appian Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Yes, Give Specify: White 3 Widowed 4 XDivorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Food Industry 12 Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma Satterfield Sherman Simonds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 s it of Health a : If item 27 I 114 Appian Way, Pasadena, Maryland 21122 <u> Arnold Jenkins, Sr. - Son</u> Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 s tment of 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/20/2011 Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gary L. Kaufman F.H. @ MMP 7250 Washington Blvd., Elkridge, Maryland 21075 M01283 23a. Part 1. Enter the dise (e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUM ONIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** HYPOXIA Se uentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: The law requires that the death certificate be executed OBSTRUCTIVE PULMONARY CHRONIC Cause (Disease or injury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical ATRIAL FIBRILLATION IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION 23e, Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 12 No 3 ☐ Probably 4 ☐ Unknown DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗹 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4  $\square$  Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D0058580 12/19/20/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bui Kanu. M.D. 3233 SUPERIOR LANE, BZI. BOWIE, MD 20715 31. Date filed (Month, Day, Year)

JAN 0 4 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Katherine Keast 5 = 30 A M 12 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A Baltimore Aques HOSPPITA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F Months Days Hours Min. May 4,1959 213-80-8959 52 Yrs. Marvland Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director MD 1 🗆 Yes 2 🖺 No Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 236 Oak Leaf Wav 21227 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. þ 1 Never Married 2XXMarried 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Roland Andrews III Verna Heber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Keast (Husband) 236 Oak Leaf Way Halethorpe, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Meadowridge Memorial Park 1/5/12 Elkridge, Maryland 21. Signa**j**ur f Funeral Service Lig 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician/ cancer panereatre disease or condition resulting in death) 4 month Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reaching to increase Examiner cause. Enter Underlying Cause (Disease or iinjury Due to for as a monsequence on executed signed by the attending physician and defeached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Box in the past 12 months? Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has be ral director, page 2 s autopsy 1 Yes 2 No Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

ne Funeral Director: After the pleted filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural Accident injury 5 Pending Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 05857 Dec 31, 2011

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State Registrar

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Brenne

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tao

31. Date filed (Month, Day,

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32. Registra

caton

's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 28 2017 Claire Bell Keefer 2:30 A M Doris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 10431 Fountain School Road Union Bridge If Under 1 9. Birthplace (State or Foreign Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) Funeral Months Hours Min (Month, Day, Year) Director 220-26-5151 1 □ M 2 🛛 F 83 1928 Maryland Nov. 2, Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location notified at Director 28a-f 1 Yes 2X No Maryland Frederick Union Bridge 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 21791 U.S.A. 10431 Fountain School Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Examiner Armed Forces? Black, White, etc. ò 1 Never Married 2 X Married þ 3altimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) 10 College (1-4 or 5+) the own home homemaker ulth and Mental Hygie 27 is marked other r traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ Viola May (unknown) James Charles Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Union Bridge, MD 21791 10431 Fountain School Rd. William F. Keefer Jr./ 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/3/2012 Johnsville, MD Johnsville Meth. Cem. 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licer athan Union Bridge, MD 21791 **Broadway** 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past Month Day Pregnant at time of death signed by the a Yes Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause þ Unknown Division of Vital Records, 1 Yes 2 No 3 Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate I 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify, 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Can of eath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier crifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29b. Signature and title of ca 2 completed cause of death (Item 23a) (Type, Print) ddress of person WHIN ST., UMON BRIDGE

Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day,

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32. Registrar's Signature

State of Maryland / Department of Health and Mer for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ CHARLES MELVIN LEWIS, JR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner UNION MEMORIAL BAUTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8.1 **Funeral** Min. 220-54-9728 **Director** 1 **X**M 2 □ F 63 Yrs 05 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State Director MD BALTIMORE 10e. Street and Number 10f. Zip Code E. 29th STREET Funeral 21218 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other that any injury or other traumatic event. the M College (1-4 or 5+) ELECTRICAL MECHANIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (Fir CHARLES MELVIN LEWIS, SR. MARY LEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Ro RITA REYNOLDS (SISTER) 1618 TAYLORS ISLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State GREENMOUNT CREMATORY 4 Donation 5 Other (Specify) 22. Name and Address of Facility VANG . Signature of Funeral Service Licensee 4905 YOCK ROAD. E 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Cardiac Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Merie Too 45 Division of Vital Records, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Natural 2 Accide 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and duay Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and the time of time of time of the time of 29a. Certifier 29b. Signature and title of certifier D006496 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 E. University Parknay Checkley Meghan 31. Date filed (Month, Day, Year) 32, Registrar's Signature State

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ital Hygiene
Reg. No. 2011 42198
Date of Death  3. Time of Death
December 31 201/ 0820 AM
4c. County of Death
Date of Birth  9. Birthplace (State or Foreign Month, Day, Year)  Country)
5-20-1948 MD
10d. Inside City Limits
1 √ Yes 2 □ No
10g. Citizen of What Country?
USA
Yes or No- n, etc.) 14. Race - American Indian, Black, White, etc.
Specify: WHITE
16b. Kind of Business/Industry
WISNER ELECTRIC
st, Middle, Maiden Sumame)
A FRITSCH
Rd. Woolford, MD·21677
20c. Location - City or Town, State
012 BAITIMORE, MD
TN GREENE FUNERAL SUS PA
BATIMORE, MO 21212
piratory arrest, Approximate Interval Between
Onset and Death
23d. Date of delivery
Month Day Year
23e. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown
24a. Was an autopsy and 24b. Were autopsy findings available prior to completion of cause of
performed death?  1 Yes 2 No 1 Yes 2 No
y one)
5 Residence 6 Other (Specify)  Describe how injury occurred
Location (Street and Number or Rural Route Number,
City or Town, State)
ue to the cause(s) and manner as stated.  time, date and place, and due to the cause(s) and manner stated.
and due to the cause(s) and manner as stated.  29d. Date signed (Month, Day, Year)
3 December 31, 2011
11thmore MD 21218

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 201 Bernard Anthony Luebben Medical 4c. County of Death Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Franklin cosedale Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland Hours Min Months 02-22-1934 217-30-3498 77 **Director** 1 🛛 M 2 □ F Usual Residence of Decede 28a-f shov 10d. Inside City Limits 10a. State 10b. County death with the Maryland 10c. City, Town or Location Examiner must be notified at **Funeral Director** 1 X Yes 2 No Baltimore Maryland N/A ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21206 USA 6023 Alta Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. ю, þ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Year or Dates. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. Specify: White "natural" Completed 3 X Widowed 4 Divorced Korea Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working ife. DO NOT use retired)

Deputy Sheriff Baltimore City and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Sheriff Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carrie D'Ambrosia Albert Luebben 19a. Informant's Name/Relationship (Type, Print)
Mrs. Colleen D. Vogel - Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catonsville, Maryland 21228 1328 Denbright Road 27 Department of Healt Important; If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corporation 01-03-2012 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Towson, Maryland 4 ☐ Donation 🥱 ☐ Other (Specify) 5305 Harford Road 22, Name and Address of Facility 21. Signature Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician yocardial disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last or as a consequence of Completed by Physician/Medical 0 Division of Vital Records, P.O. Box 68760 as. IF FEMALE: signed by the attendin d be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ Yes 2 No has this certificate 1 ☐ Yes 2 ☐ No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗹 No Other: ၉ 1 Yes 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DQA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by determined City or Town, State) 24 hours 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 284

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person

31. Date filed (Month, Day,

of death (Item 23a) Type, F

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who completed cause

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 42200 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Kristy Sue Physician/ Lederhos 20<sup>rear</sup> 29 4:50 Рм December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Baltimore Towson 5. Social Security Numbe 475–78–8011 If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) **Director** 1 □ M 2**X** F Yrs 02/14/1967 Kansas 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director notified MD Harford Bel Air 28a-f 1 X Yes 2 No 10g. Citizen of What Cou USA 10e. Street and Number ò 10f. Zip Code must be r Funeral 21014 142 Wallace Street permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces?

XYes 2 No Navy Black, White, etc ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Service Massage therapist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ unkn. unkn. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracie Eckel / Friend 142 Wallace Street, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Chesapeake Crematory 1 Burial 2 X Cremation 3 Removal from State 12/31/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee Donota Marshall 22. Name and Address of Facility Maryland Cremation Services PO nox 1413, baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death DSevdo OGSMUCTO Physician/ hronic Intestinal disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Duo to (or as a consequence of). attending physician and I for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Day Year be detached 9 Unknowed signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? b 2 X No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performe death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate it 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 🗌 Yes 2 🗌 No npletely filled in by the Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier D58303 Dreemser 29 2011 2+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Chances ST JONSON MM 6701 AMURIS W 31. Date filed (Month, Day, Y State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 2 Rhonda Lee Frazier Long Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) 217-702032 **Director** 1 □ M 2 🖵 F Aug. 28, 1958 53 Yrs MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location **Funeral Director** Md M Yes 2 ☐ No Baltimore - TGZ1 & TLONG, Khondq more, Maryland 21215-0036 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be r 21212 6189 Northwood Drive USA "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4x Divorced Completed Black er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Care First Blue life. DO NOT use retired) A and Mental Hygiene.

7 is marked other than traumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Cross Blue Shield Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 1 and 2 should be f f Health and Menta item 27 is marked other traumatic ev Robert Frazier Ruth Bailey 19a. Informant's Name/Relationship (Type, Print) (daughtgr'9). Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other trong once. ElizabethM.Frazier Wright 6189 Northwood Drive 21212 Balto,Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) X Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cem: Jan. 5, 2012 Balto, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furneral Service Licensee 22. Name and Address of Facility Calvin B. 1412 F. P Scruggs Funeral Home reston St. Balto,Md. Preston Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition ACOTE MYOC ARDIAL INFARCTION Medical resulting in death) **Examiner** ATHEROSCLEROTIC CARDIOVASCULAR DUEASE Securitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami as the burial-transi and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Live Birth
Pregnant a
Unknown Month Day Year Pregnant at time of death signed by the at d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 Inpatient 3 I DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this funeral 27. Manner of eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work? 1 🔲 Yes 2 🗀 No Natural 5 Pending death. Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined after 24 hours Medical 29a. Certifier Certifying Physician: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2

To the I

complete 3 Certifying Nurse ractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b Signature and title of certifier 29c. License number M.D.

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, 1997) 31. Da

5601 LOCAT PAVEN

BUD BALTIMORE MD 21239

d address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

TEX-CPH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 30 p M John Robert Maquire Sr. /Medical December 201 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Funeral 6. Sex If Under 24 Hrs. 7. Age (In yrs. last birthday) ice (State or Foreign 1⊠M 2□F Days Hours Director 220-20-3456 83 Mar. 21, Missouri Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location the Madical Examiner must be notified at 10d. Inside City Limits Director 1XYes 2□No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 106 Bayland Drive Unit 15 21078 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married 1 XYes 2 □ No If Yes, Give Year or Dates: timore, Maryland 21215-0036 'n, þ 1 ☐ Yes 2X No Specify Specify: White 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry should be filed within 7 and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Truck Driver Trucking ortant: If item 27 is marked other injury or other traumatic event, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be need and Mental Sylvester Clarence Maguire Thelma (nmn) Thorpe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 is Jacqueline M. Maguire / Wife 106 Bayland Drive, Unit 15, Havre de Grace, MD permit. Pages 1 and Department of Heal Important: If item 2 any injury or other ODCE. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 1-5-12 Towson, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Due to (or as a consequence of): CANDIU-/Medical Examiner Sequentially list conditions, if any, Lauring to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ntvmini Examiner Due to (or as a consequence oi). The law requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death signed by the a d be detached for 5 ☐ Other (specify) Month □Yes 2□No Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 3 Probably 4 Unknown 1∐ Yes 2∐XNo 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No this certificate has 24a. Was an autonsy perform To the Hospital or Attending Physiclan; within 24 hours after death.
To the Funeral Director: After this certifica completely filled in by the funeral director, p 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mn

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JAN 0 4 2012

32. Registrar's Signature

A. park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42203 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death · Hopth ein Physician/ Ananias Leon Millner 1215 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner An yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 X M 2 D F Months Days 02/18/1965 Country) Director NC ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD Prince Georae's Seat Pleasant 1X Yes 2 No 10e. Street and Numb 10g. Citizen of What Country? 10f. Zip Code 20743 Glen Willow Drive #8 1107 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【 No Specify: 3 Divorced Specify: Black "natural" Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ unkn. Louise Millner Geter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey Simons Millner / Spouse 1107 Glen Willow Drive, #8, Seat Pleasant, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 01/02/2012 Chesapeake Crematory Beltsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorrota Marshall to Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Arteriose <sup>D</sup>nysician, disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of, Cause (Disease or iinjury and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be within 24 burs after death.

To the Funeral Director: After this certificate has been signed by the attending physicia compileted filled in by the funeral director, page 2 should be detached for use as the bur compileted filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to death? autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 29 December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Registrar

State

31. Date filed (Month, Day, Year)

DO.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 20 11 6:10 A M Morningstar Sharon Joy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Westminster Carroll Carroll Hospice Dove House If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min Months Director 66 214-46-1691 1 M 2 X F Jun. 11, 1945 Maryland Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director 1 Yes 2 X No Westminster Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 1896 Uniontown Rd. 21158 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 0 Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify White 27 is marked other than "natural", traumatic event, the Medical Exa 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done duning most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) public school 5+ teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည George Marion Carle Ethel Muhl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 Westminster, MD 21158 Reuben Morningstar III/husband 1896 Uniontown Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 1/7/2012 Meadow Branch Cem. Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home Signature of Funeral Service Liger att New Windsor, MD 21776 310 Church St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ovmin tosooot Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death the Unknown P.0. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital: 2 WNo Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) hospice Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After To the Hospital or Attending 1 Matural 5 Pending 2 No 1 Yes Accident
Suicide Investigation filled in by the Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined after within 24 hours Medical Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 33570 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Situr State

Registrar
DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $2\,0\,$   $\,$ for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER Physician/ PATRICIA **MEYERS** ,2011 J 2:42P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, Year Jan • 15, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Hours Min Country) Missouri 82 Director 496-26-6853 Usual Residence of Decedent ıral", or items 23a or 28a-f show | Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 X Yes 2 No Frederick Maryland Frederick 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral U.S.A. 6441 Jefferson Pike, Apt. 111 21703 · death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married þ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural" Completed 3 Widowed 4 Divorced White Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 72 other than alth and Mental Hygiene.
27 is marked other than r traumatic event, the Mo within 7 Elementary/Seconday (0-12) College (1-4 or 5+) 12 homemaker own home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည James Charles McLeese Bonita Leahy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3810 Westgate Dr. Alexandria, VA 22309 Edward P. Meyers/ son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State St. Peter's Cemetery 12/29/2011 Libertytown, MD 4 Donation 5 Other (Specify) Signature of Fune al Service Lice 22. Name and Address of Facility Hartzler Funeral Home par a Libertytown, MD 21762 11802 Liberty Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onser and Death Immediate Cause (Final Physician ttc disease or condition Medical resulting in death) a consequence of **Examiner** theumoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine WKohenia burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 attending p IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy signed by the atten d be detached for u in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Day Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ature Records, Lecr 1 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed? Yes 2 No has certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) \_2 X No 잍 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred after death. Director: After 1 Natural 2 Accident 3 Suicide injury 5 Pending Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours at To the Funeral D completed filled in Medical √S Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

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7th 5+

Frederick.

30. Name and address of person who completed cause of death (Jem 23a) (Type, Print)

32. Registrar's Signatu

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۳		7	Registrar  1. Decedent's Name (First, Middle, La	ist)		007	tinoate or i	Douth		2. Date of De			4-4	3. Time of D	Death
Į.	Physicia Medi		Mildred E McL	aughlir	1					Month 12/2	4/20	11	'ear	9:30a	. М
	Examir	er	<sup>4a.</sup> Facility Name (if not institution, giv Stella Maris	e street and numb	reet and number)  4b. City, Town, or Location of D  Timonium							County of Balti		re	
	Funeral Director		212-28-6353	Sex 1 □ M 2 <b>X</b> F	7. Age (In yrs. Ia 82	st birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Bir (Month, Da 06/06	ay, Year)		9. Birth Cour	olace (State or I try) VA	Foreign
	ind show at	'n	Usual Residence of Decedent  10a. State  10b. County		10c. City	, Town or Lo	cation							Od. Inside City	Limits
	Maryla 28a-f s etified	Director	MD Balti	more	7	Towso	n							1 🗆 Yes 2	2 <b>X</b> i No
	h the Sa or S		10e. Street and Number	_	•		10f. Zip Code				10g. Citi:	zen of Wh		ntry?	
	ath wit	Funeral	212 Aigburth  11. Marital Status		lent Ever in U.S	13 1	2128		rigin? (Spec	rify Yes or No.		14. Race -		an Indian	
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	Never Married 2 ☐ Married     Widowed 4 🌠 Divorced	Armed Ford  1 Yes  If Yes, Give  Year or Dat	ces? 2 XNo		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No			Rican, etc.)			White,	etc.	
15-(	72 hou n "natu ledica	Completed	15. Decedent's (Specify only highest g	Education rade completed)		(Give	dent's Usual Occup kind of work done	during mos	st of workin	ng	16b. Kir	nd of Busi	ness/In	dustry	
212	vithin jiene. er thar the M	Con	Elementary/Secondary (0-12)	College (1-4	4 or 5+)		O NOT use retired) inter	)			Pr	int	Of	fice	
nd	filed val Hyg	Be (	17. Father's Name (First, Middle, Last)							(First, Middle	, Maiden S	Surname)			
yla	uld be I Ment narker natic e	일	Charlie Booke							ones					
Mar	2 shot th and 27 is n traum	P	19a. Informant's Name/Relationship ( Ruby McLaughl		ughte	1	ng Address (Street South O								₹1 <i>4</i>
re,	f Heal item 2		20a. Method of Disposition		20b. PI	ace of Dispo	sition (Name of	1		ate		cation - Ci			1 3
mo	a 0 4= =		1 ☐ Burial 2 <b>X</b> Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	☐ Removal from S ify)	State At.	emetery, crer lanti	natory or other place Crem	ce)	12/2	9/11	Gle	n Bu	ırn	ie MD	
3alti	permit, Page Department Important: I any injury o		21. Signature of Funeral Service Licer	59 / 1		22	. Name and Addre	ess of Facil	ity Sim	plici	ty C	rem	&	Fun Se	rv
r	Physician/		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	one cause on eac	h line.	. Do not ente						Rd I	lan	Approximate Interval Between Onset and De	een
	Medical Examiner		disease or condition resulting in death)		BRUVAS r as a consequ		ACCIDENT								
4564	n #	iner	Sequentially list conditions, if any, leading to immediate cause and Underging Cause (Disease or injury	Due to (c	r as a consequ	ence of):									
D	executed lan and urial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (o	r as a consequ	ence of):									
09,	ate be e ohysicia the buri	dical		d									_		
Box	requires that the death certificate be been signed by the attending physici should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 <b>X</b> No 9 □ Unknown		irth 2 🗍 Fetal ant at time of d	death 3	Ectopic pregnand Other (specify)	су			2	23d. Date of Month		ery Day Ye	ar
P.O.	that the ned by the detach	by Ph	Part II. Other significant conditions	contributing to de	ath but not resu	ulting in the u	ınderlying cause gi	iven in Part	t I.	23e. Did	tobacco us	se contribu	ute to tl	ne cause of dea	ath?
ds,	quires en sign buld by	ted t								1 🗆	Yes 2	No 3	☐ Pro	bably 4 🗆 Ui	nknown
of Vital Records,	The law requires ate has been sign page 2 should be	Completed								24a. Was	psy	pric	or to co	psy findings av mpletion of cau	
Re	: The cate h										ormed? 2 X No		ath? Yes	2 🗌 No	
ital	<b>sician:</b> The law r certificate has t lirector, page 2 s	) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 👿 No	Hospital:			_ Oth	ar.	ath (Check					HOODT	
of V	g Physer this	e: To	27. Manner of Death	28a. Date o	finjury	28b. Time of	28c. Injur	y at		ne 5 🗆 Resi 8d. Describe			Specify	HOSPI	<u>GE</u>
on	ending eath. or: After the funer	ficat	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not	n l	, Day, Year)	injury	M 1 🗆	Yes 2	∃No						
Division	To the Hospital or Attending Physician: within 24 hours after death safe death To the Funeral Director. After this certific completely filled in by the funeral director,	al Certificate:	4 Homicide determined	28e. Place c	of Injury - At hor g, etc. <i>(Specify)</i>		eet, factory, office		2	28f. Location ( City or To		Number o	or Rura	Route Numbe	ς
	e Hospi 124 hou e Funer bletely fill	Medical	29a. Certifier 1 Certifying Ph (Check 2 Medical Exan only one) 3 X Certifying Nu	iner: On the basis	of examination	and/or invest	tigation, in my opini	on, death o	occurred at	the time, date	and place,	and due to	the ca	use(s) and manr	ner stated
	To the within 2 To the comple	_	29b. Signature and title of certifler		10		29c. Licens					e signed (/	- 2		
	^		· CESIA	IACA	VV		KI	197	17 6		12	121	16	011	
-	7		30. Name and address of person who JACKIE JONES, C				Print)	ттма	ONTIM	, MD 2	1093	·			
	Stat	e	31. Date filed (Month, Day, Year)		gistrar's Sonatu			T T.I.I.	CHICH	, III Z	~~ <i>//</i>				
	Registra	ır	1AN 0 4 2012	13 acres	1 12. 1	A WA	145								

amend 5, per fh, g926 4-13-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] 42207 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20, АМ 2011 8:40 December John D. McCloud Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1100 Pennsylvania Ave; Apt 1102 Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Days Hours Min. (Month, Day, Year) 01/19/1943 261-64-0029 68 Director FL 1 **X** M 2 □ F 28a-f show 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1100 Pennsylvania Ave Apt 1102 21217 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 XDivorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Carpentry Carpenter 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John McCloud I Eula Mae Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5908 Sturbridge Way Portsmouth VA 23703 John McCloud III Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Glen Burnie MD Atlantic Crem 12/03/11 4 Donation 5 Other (Specify) 22. Name and Address of FacilitySimplicity Crem & Fun Ser of Funeral Service Licenses ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Myocas MINUS ABOUTS Medical resulting in death) **Examiner** YEARS word Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year signed by the a ld be detached f Yes 2 No 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ٥ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred after death. Director: After work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier completely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie December 22,2011 00041291 on who completed cause of death (Item 23a) (Type, Print) 1838 Growne Tree Rd Balto, ND 21208

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

of Vital

Division

32. Registrar's Signature

7. Age (In yrs. last birthday)

Certificate of Death

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

724

32. Registrar's Signature

I. Decedent's Name (First, Middle, Last)

613 Woodsdale Road

4a. Facility Name (If not institution, give street and number)

6. Sex

Josephine Meehan

5. Social Security Number

**Physician** 

Examiner

/Medical

30, 2011 December 11:48 P.M 4c. County of Death 4b. City, Town, or Location of Death Baltimore Catonsville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) April 12, 1923 Maryland 10d. Inside City Limits 1 ☐ Yes 2 ☑ No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. White Specify: 16b. Kind of Business/Industry Own Home 18. Mother's Name (First, Middle, Maiden Surname) Caroline Legambi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 613 Woodsdale Road; Catonsville, MD 21228 20c. Location - City or Town, State Date Baltimore, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsville. Approximate Interval Between Onset and Death 1995 23d. Date of delivery Пау Month Year 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 □ Yes 2 No 1 Tes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D Md D24766 01/03, em 23a) (Type, Print) Scule Marden Chorce have #304 Beel

Reg. No. 2011

3. Time of Death

2. Date of Death

State Registrar

29b. Signature and title of certifier

GloRIA DAMIEN

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Nancy Lee Murphy Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HONES 3ALTIMORE 8. Date of Birth
(Month, Day, Year)

Pec. 31, 1929 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛭 F Months Maryland 214-26-3404 Director 81 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD Catonsville Baltimore 10f. Zip Code 10e. Street and Numbe 10a. Citizen of What Country? Funeral USA 21228 6 Ben Woods Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 ☐ Widowed 4 🏲 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event; the Jonee. State of Maryland Senator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Mabel O'Brien John Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8315 Spring Breeze Court; Ellicott City, MD 21043 Michael Alagna 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/5/2012 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Further Service Licenses M0123 1630 Edmondson Avenue; 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ALZHEIMER'S UNKNOWN disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.Ø. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day Pregnant at time of death Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hypercholesterolemia autopsy After this certificate has performed? death? 1 Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ၉ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D70718 2011 MD DECEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

CEDRIC

DARK

6

31. Date filed (Month, Day, Year)

CATON

AVENUE

900

SOUTH

32. Registrar's Signature

21229

MD

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:401 Virginia Morrison December 85 2011 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Seasons Hospice-Northwest Randallstown 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs **Funeral** Months Hours 212-26-3974 **Director** 1 M 2 TF Kentucky July 2,1922 89 Yrs. Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location Director Baltimore Md. Dundalk 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 33 Portship Road 21222 USA er than "natural", or items; the Medical Examiner mus death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Me Elementary/Secondary (0-12) College (1-4 or 5+) Assistant Doctor 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Giles Ashley Minda Salvers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Herbert Morrison Son 33 Portship Road, Dundalk, Md. 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 1 🔲 Burial 2 😾 Cremation 3 🗆 Removal from State Bayview Crematory 4 Donation 5 Other (Specify) 2012 Baltimore, Maryland 3, 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 21. Signature of F, ne a Service Licenses methon complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate 23a Part 1. Enter the disease shock, or heart failure. List of nly one cause on each line Interval Between Immediate Cause (Final lancer Physician Lung disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician Physician/Medical certificate be Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No for Month Year Pregnant at time of death signed by the at Id be detached for Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 or Attending Physician: 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? 4 Nursing Home 5 Residence 6 other (Specify) Other: 1 Tes 2 🖪 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death. Funeral Director, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Hospital Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) US Ry apalnem. D 00057465 12/29/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209 N. SiRajapaks, MID 28355min AV 5203

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 4 2012

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John McCormick	State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death Reg. No. 20   422
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year
)	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2725 Walbrook Avenue Apt. 203  Baltimore
Funeral Director	5. Social Security Number 219-26-5118 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYYY) 9. Birthplace (State or Months Days Hours Min. Dec.14,1939 Foreign Country) MD
any	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limits
<b>.</b> .	MD Baltimore 1 X Yes 2 No
h the Maryland 3a or 28a-f she otified at once   Director	10e. Street and Number  2725 Walbrook Ave.  10f. Zip Code  21216  USA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? Na V Y 1 Yes 2 No 1 Possible Yes 2 No 1 Yes 2 No specify:  Armed Forces? Na V Y 1 Yes 2 No specify:  Specify: Black
hours after an antural?	45 December 1997 (Constitute of the property o
5-0036 ed within 72 hour sygene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 6 yrs Retired Housing Dept.
215-0 be filed w ntal Hygie riked othe ent, the M	17. Father's Name (First, Middle, Last)  Colon McCormick  18.Mother's Name (First, Middle, Maiden Surname)  Nora McNeal
D 21; should b and Men 7 is marit reve	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  John R. McCormick (son)  5824 Northwood Dr. Balto, Md. 21212
re, M 1 and 2 f Health i	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State
timo tr. Pages trment of ortant: J	Green Mount Crem. Dec.30,2011 Balto,Md.
Bal Permi Depar Impo	1412 E. Preston St. Balto, Md. 21213
Physician (Medical	failure. List only one cause on each line.  Between Onset and Death
Examiner	or condition resulting in death)  Due to (or as a consequence of):
iner	Sequentially list conditions, if any, leading to immediate
0, be executed sician and burial - transit	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.
tO,  te be executed sysician and burial - transit	™ UNPENDED AMENDED 23a,27,per me,g923 1-18-12 sm
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and appletely filled in by the funeral director, page 2 should be detached for use as the burial – transitical Certification: To Be Completed by Physician/Medical E.	
. Box the death y the atterthed for the Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ires that the signed by I be detach	1 Yes 2 ✓ No 3 Probably 4 Unknown
Records, The law requires ficate has been signage 2 should be Completed	24a. Was an autopsy findings available prior to completion of cause of performed?
tal Reccition: The lay certificate ha ector, page 2	25. Was case referred to medical 26. Place of Death (Check Only One)
n of Vit ding Physic n. After this of funeral dire	1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other Scene
Vision (or Attending free death. in by the funition in by the funition diffication	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year)  1 Yes 2 No
Division o  Division o  spital or Attending  sours after death.  neral Director: After filled in by the func  Certification:	3 Suicide 6 Could not be determined Could not be Homicide Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	
	29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  December 26, 2011
	30. Name and address of person who completed cause of death (Item 23a)  Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
State Registra	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death De Physician/ 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore ioun 10Wson 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Director Maryland 28a-f show 10c. City, Town or Location 10b. County must be notified at Director 1 Ves 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 5 23a Funeral 123 or items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 2 1100 Yes 2 No Specify 3 ₩idowed 4 ☐ Divorced "natural" other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) and Mental Hygiene. life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Domest Be 's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) 18. Moth ၉ 19b. Mailing Address (Street and Number or item 27 20b. Place of Disposition (Name of cemetery, crematory or other Date 20c. Location -20a. Method of Disposition Department of h Important: If ite any injury or ot Burial 2 Cremation 3 Removal from State Mestro 4 Donation 5 Other (Specify) Mure on Funeral Service License mu Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one of Onset and Death Immediate Cause (Final P y i ian/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be exec attending physician for use as the huria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 month 1 Yes 2 No ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_\_ Month Year Day signed by the at d be detached for 1 Yes 2 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 perform within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Medical Certificate: To Be Other: 2 No 1 Tyes ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 🔾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) Signature and th DOOTIZ -20-11 and address of person who completed cause of death (Item 23a) (Type, Print) 4102 · Cher 6701 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 42213 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 23, 2011 6:03 AM M Donald S. O'Reilly Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Casey House 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday, **Funeral Director** 145-24-8779 1**X** M 2 □ F Oct 7, 1931 New Jersey 80 ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MDGaithersburg Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 419 Russell Avenue #416 20877 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces? 1 X Yes 2 If Yes, Give Black, White, etc. 0 þ 1 Never Married 2 K Married 2 🗌 No Baltimore, Maryland 21215-0036 nan "natural", o Medical Exam 1 Yes 2 X No Specify. Specify: white Completed 3 Divorced 4 Divorced 152-54 Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the 12 retail sales menswear Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental h ျှ Stuart Brown O"Reilly Dorothy Francis McFarland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 Russell Avenue #416 Gaithersburg, MD 20877 Natalie O'Reilly/spouse f Health or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 D Other (Specify) 23 Name and Address of Facility Board 655 W. Baltimore Street 21201 MD Baltimore, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate or beart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) pancreatic cancer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Yes 2 9 Unknown signed by the ar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has 1 Yes Yes Hospital or Attending Physician: completely filled in by the funeral director, Be ( 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

29c. License number

D0060634

Rockville, Maryland

29d. Date signed (Month, Day, Year)

2011

Dec 23.

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Bindu Joseph MD

Box 68760

P.O.

Records,

Division of Vital

Casey House

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 42214 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20, 2011 December 2:40 PMM Doris W. Poehler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Sukesville Fairhaven Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 20 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🗓 F Maryland Director June 220-07-0899 90 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21784 7200 Third Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Armed Forces? Black White, etc. 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 nan "natural", e Medical Exan If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: white Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the gift wrapper retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should Le file
of Health and Mental H
item 27 is marked of ည Melvin Charles Wann Mary Elizabeth Wolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Doris P. McIntire/daughter 11500 Pebble Creek Drive Lutherville, MD 21093 per it. Page 1 and 2 Derartment of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) of Funeral Service Licensee state Anatomy Board 655 W. Baltimore Street Baltimore, 21201 MD Part 1. En. the lisease, it complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he in ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End Stage demention Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last X Due to (or as a consequence of): g physician are the burial-t Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year signed by the a d be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 X No မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) 5 Pending Division 1 🗆 Yes 2 🗆 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42215 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 December 11:56 PM Medical Andre Pearson 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick 420 Military Road Frederick Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Min (Month, Day, Year) 217-56-1278 **Director** 1 🛛 M 2 🗆 F Oct 20, 1951 Washington DC 60 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 No MD Frederick Frederick 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 420 Military Road 21702 IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. Completed by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: "natural", 3 Widowed 4 Divorced black Year or Dates Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Secondary (0-12) concrete finisher construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Lillie Belle Reese Eddie Buster Pearson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 420 Military Road Frederick, MD 21702 Dianne Pearson/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Ronal d State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that causes shock, or heart failure. List only one cause on each line. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work hours after death. 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npletely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of contified

State Registrar 30. Name and address of person who

2012 4

31. Date filed (Month. Dav. Year)

Box 68760

P.O.

Division of Vital

cause of death (Item 23a) (Type, Print)

32. Registrar's gnatu

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Registrar DHMH 17 Rev 06-2011

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State

N. S. Rajapakse, M.D.

Year) - - ·

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42217 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Phan 1134 PM Naoc December 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore . Social Security Numb 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Vi<u>etnam</u> 219-59-6448 1 - M 2XX F 05/15/1946 64 Director Usual Residence of Decedent Show 10b County Frederick 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director Frederick 28a-f 1 X Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 once. 3701 Spicebush Way 21704 Funeral Vietnam 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖸 No Specify: Specify As i an 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0wner Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ unkn. unkn. 19a. Informant's Name/Relationship (Type, Print) Lawrence Pham / Son-In-Law 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3701 Spicebush Way, Frederick, MD 21704 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. State 1 Burial 2 X Cremation 3 Removal from State 12/31/2011 Atlantic Crematory Glen Burnie, MD 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee Dorota Marshal Name and Address of Eacility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Hepatocellular Carcinoma Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed attending physician and for use as the bunal-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Day 4 Pregnant at time of death
9 Unknown Month Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Hepatitis C Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of Hepatitis B exposure 24a. Was an autopsy performed? death? 2. No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 2 No To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dit 1 Nonpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pendina 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of gertifier 29c. License number December 30, 2011 067594 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chery Hepp N 31. Date filed (Month, Day, Year) Street, Baltimore Hepp MD Greene State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 127/27/2011 2301 George B. Purdy рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Montgomery General Hospital Olnev Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min 19726/1956 Director unk 1**X**□ M 2 □ F Wash. D.C. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location aţ Director notified 1 Yes 2 No MD Montgomery Silver Spring 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 20906 USA 3115 Whispering Pines Drive 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. ò 1 Yes 2X No
If Yes, Give
Year or Dates. 1 Never Married 2 X Married SpecifyWhite 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Landscaping Landscaper 9Yrs lith and Mental Hygie 27 is marked other r traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Vincent Purdy Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Christine Purdy Wife 3115 Whispering Pines Drive Silver SpringMD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State Atlantic Crem 12/31/11 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signature of Funeral Service Licensee ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardiemvona disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPI DM. 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No After this certifica funeral director, p To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print)

(A) 18701 Prince Ph.l.p A-31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2012

Registrar

04

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 -** For State Registrar 42220 Reg. No. Z Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 32 M Deborah Ann 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A University of Maryland Medical Cente altamore If Under 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min (Month, Day, Year) 212-04-2961 Director 1 🗆 M 2 🗓 F 44 Oct. 4,1967 Maryland Usual Residence of Decedent show 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c, City, Town or Location Director Forest Hill 1 ☐ Yes 2 X No MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 540 Walters Mill Road 21050 United States or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2X Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: "natural", 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry Give kind of work done during most of working (Specify only highest grade completed) filed within 72 all Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Years Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ည Page 1 and 2 should be Mary Luca William G. Gray, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 540 Walters Mill Road Forest Hill, MD f Health Mr. Matthew S. Rossi(Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o once. cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Oak Lawn Cemetery 12/30/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ cardiac tamponade disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MONTINS metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine pule to for as a consequence on as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 Yes 2 No Day Year Month Pregnant at time of death 1 ☐ Yes 2 ⊭ 9 ☐ Unknown signed by the detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy this certificate has 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ✓ Yes 2 ☐ No Hospital Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide work?
1 \( \sum \) Yes 2 \( \sum \) No iniury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 29c. License number 093014524 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9,16a&b, 18&19a&B per ANA BD G927 5/21/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2240 OSEPH SULINAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY CROSS HOSPITIAI SPRIN \_4 6. Sex ear If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Min. Hours Washington, DC 78-30-4602 **Director** 1 M 2 - F Š 1927 HUNK Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland at Director items 23a or 28a-f s er must be notified 1 Yes 2 No SPRING MA MONTGOMER 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral COLONIA .091 8210 S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 "natural", or ğ Yes Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 M No Specify: Specify: WHLTE If Yes, Give Year or Dates. W Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Transportation Elementary/Secondary (0-12) College (1-4 or 5+) UNK Cab Driver YOR UNK Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Catherine Hayes permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic s UNK other traumatic 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

801 Summit Ave. Alexander, VA 22302 19a. Informant's Name/Relationship (Type, Print) Katie Wagner-neice 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ₩ Other (Specify) in state 4 Donation to of Funeral Ser 21. Sign 22. NarStatted And Ecothy Board 655 W. Baltimore Street ce Licenses na Id Director Baltimore, MD 2120 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock refer the disease, of complications that cause shock refer the disease, of complications that cause on each line Immediate Cause (Final disease or condition Interval Between Onset and Death PNRUMONI Phylician Medical resulting in death) Due to (or as a consequence of) Examiner MULTIINPARC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-transit HYPERTENSION Due to (or as a consequence of) nding physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Other (specify) Pregnant at time of death been signed by the a should be detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 № No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 ( has autopsy perforn death? 1 Yes 2 No this certificate Yes After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred Certificate: injury 5 Pending Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the f Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SILUER FORRST GLEN RD 1200 TIGOL NEGUS 31. Date filed (Month, Day, Year)
IAN 0 4 2012 Registrar's Si∎nature State Registrar

amend item 11 per inf g931 9-21-12 vt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 3. Time of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Theodore Suess recember Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Stimore aryland Grenera Under 1 Year If Under 24 Hre 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** (Month, Day, Year) Months Hours 579-50-4464 **Director** 1 X M 2 - F Dec 21, 1938 Pennsylvania 73 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland notified at Director 28a-f 1X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be r Funeral 21201 USA 501 W. Franklin Street "natural", or items edical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 X Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: white 3 Widowed 4 Divorced Completed er than "natur , the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Nany injury or other warms and some. education teacher unk unk Be unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 Halleck Street Fredericksburg, VA 22407 Ralph Purcell/step brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 💢 Other (Specify) in of Euneral Sonice Licensel State and Address of Facility ard 655 W. Baltimore Street rector 21201 MDBaltimore, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, owneart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ 20 Aspiration Preunon Medical Due to (or as a consequence of) **Examiner** Dyanhais Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-trar that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Other (specify) 4 Pregnant : 9 Unknown Pregnant at time of death signed by the at id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? director, page 2 should be 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed?

Yes 2 No death? 1 ☐ Yes 2 ☐ No certificate 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 IDOA After this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) w

State Registrar Name and address of person

31. Date filed (Month, Day, Year) JAN 0 4 2012

Howard

who completed cause of death (Item 23a) (Type, Print)-

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Stevens 28 2011 **Physician** nanes /Medical City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner son secours Himore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5-2-1939 der 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number Days Hours Min. **Funeral** 72 Yrs. Months 1 M 2□ F 245-60-6081 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location hours after death with the Maryland 10a. State 10b. County 28a-f show 1 Yes 2 □ No other traumatic event, the Medical Examinar must be notified at Director 3a/timore MS 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Num ō 21217 1809 items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼res 2 No 11. Marital Status 1 ☐ Never Married 2 Married 1 □Yes 2 No Specify. Black Specify: Baltimore, Maryland 21215-0036 If Yes, Give Ye ar or Dates: "natural", or 2 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. OO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than river 18. Mother's Name (First, Middle, Maiden Surna 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental HVania rancis City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, formant's Name/Relationship 1 and 2 st of Health ar Irevino lerrace mo 20708 Laurel amela 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of Green Mount Baltimore Wills Pages 1 iment of Hi 20a, Method Disposition permit. Pages
Department of
Important: If it
any Injury or o 3 Removal from State 1 Durial 2 Cremation 1-6-2012 -orest 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility V value 21. Signature of Fungral Service Licens 8728 Liberty MD 21133 Road Krune Approximate Interval Between Onset and Death 23a. Part1. Ent fr he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or expiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final s a consequence of): **Physician** disease or condition resulting in death) /Medical neumo Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be 0 Physician/Medical attending p IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death been signed by the attendin should be detached for use 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 Tyes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Pres 2 No 3 Probably 4 Unknown nseine Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 NO 2 110 1 ☐ Yes 1 ☐ Yes certificate 26. Place of Death (Check only one) r this certificar 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Yes 2 1 | 1√0 ၉ 28d. Describe how injury occurred After thi funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Deatural Certification: 5 Pending 1 ☐ Yes 2 ☐ No ieral Director: A filled in by the ft investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Street Baltimore M 2000W BUNOVAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State S. parker Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 3:15 PM Donald Wray Spratt 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner HARFORN BelAir Beiair Health and Rehebilitation Cente 8. Date of Birth (Month, Day, Yea June 7, Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Country)
New York 1**X** M 2 □ F Months Days Hours 071-18-0766 Director l'924 87 June Usual Residence of Decedent should be filed within 72 hours are and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show arke event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City. Town or Location Director 1 ☐ Yes 2X No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 128 W. Ring Factory Road, Apt. 1269 21014 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Physician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wray Lionel Spratt Gladys (unk) Deevy permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Spratt / Wife 128 W. Ring Factory Road, Apt. 1269. Bel Air. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 1/2/2012 Towson, Maryland ture of Funeral 22. Name and Address of Facility 21. Sign McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or complications Approximate Interval Between Immediate Cause (Final Onset and Death Pleunul Physician/ maith Massive disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of and that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-t Physician/Medical certificate be 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ P.O. Box in the past 12 months? Month Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown the been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Division of Vital Records, icate has been s ; page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? the Hospital or Attending Physician; The Inin 24 hours after death.

the Funeral Director, After this certificate he mpleted filled in by the funeral director, page 1 🔲 Yes 2 No Yes 2 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the 29b. Signature and title of certifier 29c. License number 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print)

Scoth Haswill 500 (Upper Cherplake De 121 31. Date filed (Month, Day, 32. Registrar's Signatur State Registrar

Sonald

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	se Type or Pri					_		_	
		For State		State of Ma	arylan			Health and I	Mental Hy	giene	001	1 10005
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Physicia Medic		Doro	thy			Sir	nmo-	di	Decemb	oer De	<sup>3</sup> 30 201	
Examin				give street and number)			4b. City, Town, o	r Location of Death	1	40	c. County of Deat	
P		5. Social Security No	n Meado		a (In vrs. Is	st birthday)	If Under 1 Year	III If Under 24 Hrs.	8. Date of Bir		Baltimor   G Bir	*E thplace (State or Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a, Informant's Na				19h. Mailir	a Address (Street	and Number or Ru			r Town. State. Zi	p Code)
nd 2 sh ealth a <b>n 27</b> is er trau		Barbara '	Vergauw	en/ Daughter	^			Court Ph		_		
je 1 ar it of He Ifiter or oth		20a. Method of Disp 1 Burial 2		3 Removal from State	C	emetery, cren	sition (Name of natory or other plac		Date		ocation - City or	
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Physician: The lav r this certificate haveral director, page 2	일		Mo			ER/Outpatier		4 Wursing F	T T		6 Other (Spec	cify)
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pital or ours aft eral Di	SalC	00- 0-48 4										otod
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical Certificate:	(Check 2	Medical E:	Physician: To the best of xaminer: On the basis of ex Nurse Practioner: To the	kamination	and/or invest	igation, in my opini	on, death occurred	at the time, date	and plac	e, and due to the	cause(s) and manner stated
To th within To th comp	_	29b. Signature and	title of certifier	MA	1	W	29c. Licens	e number		29d. Da	ate signed (Mont	h, Day, Year)
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DHMH 17 Rev 7/2009

11-09858 Carla Schulte Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

6

ana Schulle		1- For State Registrar	State	e of Maryland /		rtificate d		and Ment		Reg. No.	201	1 4222
Physici		Decedent's Name (F	irst, Middle,La	st)					2. Date of De	eath	Year	3. Time of Death 1615 hrs
····Gicar Exam	mer	Carla  4a. Facility Name (if no	ot institution, gi	S. ve street and number)			Schulte 4b. City, Town	, or Location o	Decemb f Death		011 County of Dea	
,		Union Memoria	al Hospital				Baltimore	•			V/A	
Funeral Director		5. Social Security Num	ber 6. S			ast birthday)	If Under 1 \ Months E	Year If Under	Min		D/YYYY) 9. B Fore	
Director	ľ	214-78-8396 Usual Residence of De		M 2XF	57	Yr		,	04/07	7/1954	С	ountry) MD
yaa			c. County		10c. City,	Town or Loca	ation	-				10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ō	MD	Harford		Fall	ston						1 Yes 2 X No
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5-0036 led within 72 hours after death with the Maryland stygener.  The stygener of the style of	_	2718 Park St	nire Cour	12. Was Decedent	Ever in II	s 113 W	21047	Hispanic Orio	in? ( Specify Yes or N	U.S./		rican Indian, Black,
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after or ral", o	Ą			d If Yes, Give Yaar or Dates:		1	Yes 2X		-77			hite
2 hours "natu	ted	15. Decedent's Educa Elementary/Seconda		only highest grade com College (1-4 or 5			nt's Usual Occu nost of working		ind of work done use retired)	16b. Ki	nd of Business	/Industry
15-0036 iled within 72 Hygiene. d other than '	Completed	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,	Depend	dant			Depe	endant	
15-0( filed wi Hygier d other		17. Father's Name (Fire	st, Middle, Las			Cala1.	_		s Name (First, Middle		•	
21215-0036 sold be filed within 7 Mental Hygiene. marked other than c event, the Medica	To Be	Charles 19a. Informant's Name/	/Relationship (	A. Type, Print)		Schul to		COVas		S.		Sherrard e, Zip Code)
D es B is	1 8	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Gardner, Guardian 2718 Park Shire Court, Fallston, MD 21047										
= 8 A B 3		20a. Method of Disposi		Removal from Sta		Place of Dispo crematory or o	sition (Name of ther place)	cemetery,	Date	20c, Lo	ocation - City o	r Town, State
Baltimore, permit. Pages 1 at Department of Hee Important: If ite injury or other tr		4 Donation 5 21. Signature of Funera	Other Specify	/:		kwood Ce			01/07/2012		timore, M	D
Bal permi Depar Impo injur	Ů,	11.0	ai service Lice	> Blair		- 1	Name and Addr 05 Harfor	_	Leonard J. Baltimore,MD	Ruck,	, Inc.	
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of Vital Records, ag Physician: The law requir the certificate has been some director, page 2 should	To Be	examiner?		Hospital: 1 Inpatier	nt 2 🗸	ER/Outpatien		Other -	Check only one)  Nursing Home 5	Residen	ce 6 Othe	er:
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Division  To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	Medical	one) 2 Med		r:On the basis of exam end manner stated.	nination ar	nd/or investiga			surred at the time, dat			
	2	29b. Signature and title	or certifier	110				ense number C.M.E.			ate signed (Mo ary 1, 2012	onth, Day, Year)
		30. Name and address	of person who	completed cause of de	eath (Item	23a)				Janu	., 1, 2012	· 
(La)		Laron Locke M	D Assis	tant Medical Exa	,		altimore Str	eet, Baltim	ore, MD 21223			
Si	tate	31. Date filed (Month)	ev. () ar 4 2	32 Registrar	s Signatu	1. Sa	New?					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7:25 PM FRANCIS SCRIVENER XIAVIED2 30 2011 DEC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HUMARD HOWARD COUNTY GANDELL HOSPITAL (DUMV31A . Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Days Hours 214-54-4836 **Director** 1 XXM 2 - F 63 July 23, 1948 Maryland Usual Residence of Dec 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Funeral Director be notified 1 🗆 Yes 2 😿 No Maryland Howard Columbia 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? 23a 5315 Columbia Road Apt. D 21044 U.S.A. items permit, Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Innportant: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Howard County Public Elementary/Secondary (0-12) College (1-4 or 5+) Schools Principal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Minnie Elizabeth Mort Joseph Martin Scrivener 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Scrivener 5709 Harpers Farm Road Apt. B; Columbia, Maryland 21044 (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 1-1-2012 Glen Burnie, Maryland 4 Donation 5 Other (Specify) Signature of Pureral Service Lis 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the diseaser of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final AWTO NOSPINATINGY Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 20032145 Production A Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner NOW SMALL COLL LUNG CANZER To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury III B the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No for Pregnant at time of death 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è MULTIROCAL ATMAL TARETY CAMPIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Medical Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? ROMAL INSUFFICIENCY 24a Was an page 2 has performe 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Hospita Other: 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending s after death.
I Director: Af 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number filled in by determined within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D36974 DEC 30. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID 21544 10710 CHARTER DR 4310 Cozumaia mo MAUNION CTV 32. Registrar's State Registrar

11-09767 Daniel Schneider

Please Type or I State of	pies Are Legible. Hygiene 2 0	pp and	4222	
I- For State Registrar	Certificate of Death	Reg. No.		
Decedent's Name (First, Middle,Last)		Date of Death     Month Day Year	- 1	Time of Death
Daniel Leonard Schnei	der	Month Day Year December 28, 2011		1500 hrs

		1- For State Certificate of Death Reg. No.													
Physicia	_	Decedent's Name (First, Middle Last)								/ear	3. Time of Death				
edical Examir	iner Daniel Leonard Schneider December 28, 2011								1500 hrs						
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death							th							
		University Hospital					Baltimo	re							
E	4	5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)		If Under	1 Year	If Under	24Hrs.	B. Date of E	Birth (MM/DD/YY	YY) 9. Bi	irthplace (State or	
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with	ᅙ	11. Marital Status	12. Was De	cedent Ever in U.	S. 13.	Was	Decedent	of Hisp	anic Origir	n? (Spe	cify Yes or N	No- 14. Ra	ace - Ame hite, etc.	erican Indian, Black,	
eath item	Funeral	1 X Never Married 2 N	İ	If Yes	s, specify	Cuban, I	viexican, i	Puello K	ican, etc.)	"					
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urs af	흵	15. Decedent's Education (Spe	or Dates: ecify only highest gra	ide completed)	16a. Dece							16b. Kind of	Business	s/Industry	
2 hou	Completed	Elementary/Secondary (0-12)	College (	1-4 or 5+)	durin	g mo:	st of worki	ng lite. L	OO NOT u	ise retire	a)				
36 hin 72 than than	희		2			U	nemplo	yed				Ur	nemplo	oyed	
ber Ber	탕	17. Father's Name (First, Middle	, Last)		_			18	3.Mother's	Name (I	First, Middle	, Maiden Surna	me)		
<b>た</b>	Be	Martin F. Schneid	er						Judit	th M.	Morgan	roth			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		THE CHIT I. DELINITIES										own, Star	te, Zip Code)		
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. m 27 is marked other than "matural", or items 23a or 28a-f she numatic event, the Medical Examiner must be notified at once	-1	Martin F. Schneid		er)	406	1 F	ragile	e Sai	1 Way	E11:	icott (	lity, Mary	yland	21042	
md 2 salth cm 2 raun	ŀ	20a. Method of Disposition	(====	20b. F	Place of Dis	posit	ion (Name	_			Date			or Town, State	
nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. f: If item 27 is marked other than "natural", other traumatic event, the Medical Examines	П	1 X Burial 2 Cremation	n 3 Removal	i oili otato j	rematory o			ъ .		1 0	0010	01.1.	.11	. Mararal and	
Page Page nent ant:		4 Donation 5 Other S		1001	umbia l				-	1-2-				e, Maryland	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tt injury or other traumatic event; the Medium or other traumatic event; the Medium or other traumatic event; the Medium or other traumatic event; the Medium or other traumatic event; the Medium or other traumatic event; the Medium or other traumatic event; the Medium or other traumatic event; the Medium or other traumatic event; the Medium or other traumatic event; the Medium or other traumatic event; the Medium or other traumatic event; the Medium or other traumatic event; the Medium or other traumatic events the Medium or other events the Medium	- [	21. Signature of Funeral Service Licensee 22. Name and Address of Funeral Service Licensee 5555 Twin Knol.									ecility Witzke Funeral Homes, Inc. s Road Columbia, Maryland 21045				
<b>m</b> 88 <b>m</b>	- 1	ALITE	Tadoma												
Physician		23a. Part I. Enter the disease, of failure. List only one cause	r complications that	caused the death.	Do not ent	er the	e mode of	dying, s	uch as ca	rdiac or i	respiratory a	arrest, shock, or	neart	Approximate Interval Between Onset and	
/Medical.	1.0	Immediate Cause (Final disease a, Multiple Injuries													
Examiner	- 1	or condition resulting in death)		a consequence of	f):									1	
	- 1	Sequentially list conditions,	b												
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	miner	cause. Enter Underlying Cause (Disease or injury that initiated  c.  Due to (or as a consequence of):													
ed sit	Exa	events resulting in death) Last	,	a consequence o											
<b>Records, P.O. Box 68760,</b> The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	<u>ख</u>	[] UNDENDED	dAMENDED												
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Box 68 e death certif the attending ed for use as	/si	1 Yes 2 No 9 U	nknown 9 Unk	nown	0	Out	lei (opoon					4			
that the death certificated by the attending detached for use as t	Physiciar	Part II. Other significant cond	itions contributing	to death but not re	esulting in t	he ur	nderlying	ause gi	ven in Par	rt I.	23e. Di	tobacco use c	ontribute	to the cause of death?	
P.C.	<u>る</u>										1 🔲	Yes 2 🗸 No	3 Pr	robably 4 Unknown	
ords, F v requires s been sign should be	Completed										24a. W	as an 24	4b. Were	autopsy findings available	
Cord	ple											topsy rformed?	prior to death?	o completion of cause of ?	
Recorder The la cate has page 2	E											s 2 V No		Yes 2 No	
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Vital F ysician; his certifi director,	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpa	tient	3 DO	)A	Other <sub>4</sub>	Nursing	Home 5	Residence	6 Ott	her:	
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F. Af	<u>.</u>	1 Natural 5 Pe	nding Dec 2	th, Day Year) 8, 2011	1258 hrs	S		1 Y	es 2 🗸	No S	subject ju	imped off 6t	n noor	or a note:	
SiG Affer r dear ector	cat		estigation 2Be. Pla	ace of Injury - At h	ome, farm,	stree	t, factory,	office bu	uilding, etc	c. :	28f. Locatio	n (Street and No	umber or	Rural Route Number, City	
Division of Vital Records, P.O. pital or Attending Physician: The law requires that tours after death.  eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detax	Certification:	det	uld not be	y) Hotel/Mote						1	or Town 0207 Win	n, State) copin Circle, (	Columbia	a, MD	
E 6 5 E		4 Homicide 29a. Certifier Certifying	Physician: To the b			neer re	red at the	time da	te and nie	- 1					
n 24 In E Fu	cal	(Check only one) 1 Certifying Medical Ex	Physician: To the basi	est of my knowled s of examination a	nd/or inves	stigat	ion, in my	opinion,	death oc	curred at	the time, da	ate and place, a	nd due to	the cause(s)	
To the Hos within 24 h To the Fur completely	Medical	2	and manne		,				number					Month, Day, Year)	
	Σ	29b. Signature and title of certi	ilei		01		290.					Decemi			
		6 W	1	11	1		)	O.C.N	VI.□.			Deceini	JCI 43,	2011	
, I		30. Name and address of person	on who completed ca	use of death (Iten	1 23a)	(		_							
0		Zabiullah Ali, M.D.	Assistant Med					Stree	et, Balti	more,	MD 2122	2.3			
S	tate	31. Date filed (Month, Day, Yea		Registrar's Signat	ure far	Kar	1								
Regis	trar	JAN 0 4 4	UIL COME	m p.	Mar Carl										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 23 Irene K. Smith 20ÎÎ 9:05 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Heartland Assisted Living Ellicott City Howard 5. Social Security Number 9. Birthplace (State or Foreign Country Maryland **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 🗆 M 2 🗓 F Days Min. Months 213-16-5507 Hours Julie 15 34, 1921 90 Director Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Howard Columbia 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. eral er than "natural", or items 23a the Medical Examiner must by 10001 Windstream Drive #203 21044 Fun 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XXNo Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 72 hours after Yes Give 1 ☐ Yes 2 X No Specify. White 3 X Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Tin Inspector Bethlehen Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John H. Kurt Julia Jendrick permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Smith (Daughter) 2603 Rockhampton Road Ellicott City, Maryland 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Moreland Memorial Park 1-3-2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Signatury of Funeral Service Nice # e 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Pa Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Alzheimers Dementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-trai Due to (or as a consequence of) resulting in death) Last nding physician use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 2 XNo signed by the a q 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2XX No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed?

Yes 2 No 2 🗆 No 1 Tyes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Assisted Living ᅆ 1 Yes 2 XNo Other: this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death nours after death.

neral Director: After the funeral of the funeral filled in by the funeral filled in the funeral fille Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completed fi 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practyoner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ロインイイン m > 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andy Lazris, M.D. 6334 Cedar Lane Columbia, Maryland 21044

DHMH 17 Rev 7/2009

State Registrar

32. Registrar's Signature

	Di
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene.
	Phy
	Phy: /M: Exa
Division of Vital Records, P.O. Box 68760,	o the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

an	1 - State Registrar  1. Decedent's Name (First, Middle, Last)	e of Maryland / Depa <i>Cei</i>	rtificate of Death		.No.2011	4 2 2 3 3. Time of Death			
al	Maxwell	Shaw		December	<sup>Day</sup> 30, 2011	10:02 A			
ner	4a. Facility Name (If not institution, give street ar Riverview Nursing Home	e	4b. City, Town, or Location of Death ESSEX		4c. County of Death Baltimore				
	5. Social Security Number 6. Sex 1 № M 2 □	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Youly 22, 1	917   91 Birthp Coun Germ	lace (State or Fore try) any			
ector	Usual Residence of Decedent  10a. State  10b. County  Maryland  Baltimore	10c. City, Town or Lo	ndalk			0d. Inside City Lim 1 ☐ Yes 2 🌠			
al Dir	7833 Bank Street		10f. Zip Code 21 224	109	10g. Citizen of What Country?  USA				
d by Funeral Director	1 Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ed Forces? Yes 2 □ No s, Give r or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerti 1 ∐Yes 2 <b>X</b> No Specify:	o Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.  Specify: White				
Completed		eted) (Give life. i	dent's Usual Occupation kind of work done during most of won DO NOT use retired)	king	b. Kind of Business/Inc				
To Be Col	12 years  17. Father's Name (First, Middle, Last)  Unknown	Sa			Photographer e, Maiden Surname)				
	19a. Informant's Name/Relationship (Type. Print		ng Address (Street and Number or Ru						
11 0	JohnBarcase Step-9  20a. Method of Disposition  1	20b. Place of Dispo		Date 20	ola, Maryla c.Location-City or To ltimore, M	wn, State			
	4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	0000	2. Name and Address of Facility Dunelly Funeral Ho 110 Sollers Point	ome Of Dun	dalk,P.A. dalk,MD. 2	1222			
a E	Sequentially list conditions, Tarry, Internal Latter Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
Physician/Medic	in the past 12 months?		□ Ectopic pregnancy □ Other (specify)		23d. Date of delive	ery Day Year			
by Ph	Part II. Other significant conditions contributing		nderlying cause given in Part I.	I. 23e. Did tobacco use contribute to the cause  1   Yes 2   No 3   Probably 4					
å p	0)			24a. Was an autopsy performed?  1 \[ \rac{1}{2} \text{ Yes} \] 24b. Were autopsy findings availa prior to completion of cause death?  1 \[ \rac{1}{2} \text{ Yes} \] 2 \[ \rac{1}{2} \text{ No} \]					
Completed b				performe 1 □ Yes 2	ZNo 1 ☐ Yes				
Be Completed	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpatien	_ Other: _	1 ☐ Yes 2 th (Check only one)	2Ño 1 ☐ Yes ce 6 ☐ Other (Specif	2.DNo			
Be Completed	examiner?  1 Yes 2 No Hospital:  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	1 ☐ Inpatient 2 ☐ ER/Outpatien  Date of Injury (Month, Day, Year)  Place of Injury - At home, farm, str building, etc. (Specify)	ont 3 DOA Other: 4 Mirsing H  and 28c. Injury at Work?  M 1 Yes 2 No	th (Check only one) tome 5 ☐ Resident 28d. Describe how	aNo 1 ☐ Yes  the 6 ☐ Other (Specifinjury occurred	2 <u>1</u> 100			
Certification: To Be Completed	examiner?  1 Yes 2 No Hospital:  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier Check only 2 Medical Examiner: On	Date of Injury (Month, Day, Year)  Place of Injury - At home, farm, str building, etc. (Specify)  To the best of my knowledge, deat	ont 3 DOA Other: 4 Mirsing H  and 28c. Injury at Work?  M 1 Yes 2 No	th (Check only one) tome 5 Resident 28d. Describe how  28f. Location (Stre City or Town,	aNo 1 ☐ Yes  the 6 ☐ Other (Special injury occurred  et and Number or Rura State)  use(s) and manner as s	al Route Number,			
Be Completed	examiner?  1 Yes 2 No Hospital:  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier (Check only one)  29b. Signature and title of certifier	Date of Injury (Month, Day, Year)  Place of Injury - At home, farm, str building, etc. (Specify)  To the best of my knowledge, deat the basis of examination and/or in	ont 3 DOA Other: 4 Mdrsing H  f 28c. Injury at Work?  M 1 Yes 2 No  reet, factory, office	th (Check only one) ome 5 Resident 28d. Describe how  28f. Location (Stre City or Town, a, and due to the cau	aNo 1 ☐ Yes  the 6 ☐ Other (Special injury occurred  et and Number or Rura State)  use(s) and manner as s	al Route Number,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Per DVR G923 1704/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 0206 M December TAKAHASH Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** TOWK 0 Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Apr 13, 9. Birthplace (State or Foreign Country) Indiana **Funeral** 1 □ M 2 🂢 F T925 306-20-6112 Director 86 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 T No MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 483 Heron Point 21620 USA death \ 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married ģ 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify 3 X Widowed 4 □ Divorced Specify: white Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. 5+ educator school system Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be file h and Mental h 7 is marked ot Arthur Fobes Ellis Mary Esther Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Nancy Takahashi/daughter 18249 Paladin Drive Olney, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Oper (Specify) of Funeral Prvice Licens State Anatomy Board 655 W. Baltimore Street Signal Director Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE Physician/ HEART disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ears HURTIC VERE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami The law requires that the death certificate be executed and-tran Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Day Pregnant at time of death detached 9 Unknown 9 Unknown P.O. been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSIVE CARDIOVASCULAR Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? ARTHRITIS 24a. Was an KHEUMATUID has page 2 autopsy performe certificate 2 🕱 No 1 🗌 Yes Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certific leted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 6 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Tipleted 1

State Registrar (Check

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Helen Andrews Noble 122 Speer RD Ste 5

32. Registrar's Signature

within 2.

To the F
complet

2 Medical Examiner: On the pasis of examination and/or investigation, in the opening, seath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

00415

Chestertown, Md 21620

3

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 14 per th g923 1-4-12 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death /lonth Physician/ Medical Name (if not institution, give street number City, Town, or Location of Death nty of Death Examiner Sex 1 M 2 D F 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day Months Hours Director Yrs 08-665 AND Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status American Indian Armed Forces?

1 Yes 2 No
If Yes, Give te. etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【No Specify: 3 Widowed 4 Divorced **Black** Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Indust (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnan ည GILBERT CATO ELLA BELI 19a. Informant's Name (Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or 3161 other . Method of Dispo 1 ☐ Burial 24 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of F
Important: If ite
any injury or ot Cren cemetery, crematory or other place) nation 3 Removal from State Other (Specify) 4 Donation 1-6-2012 BALTIMORE, MARYLAND 5 🗆 METRO CREMATORY D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Fundal Se IONATHAN once, 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1 Inter the disease, or complications that caused the death. Do not e shock or heart failure. List only one cause on each line. mode of dyin such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, it and the sequential cause. Enter Underlying Cause (Disease or iinjury that initiated events are life in death. Examine as a cons -transit and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical The law requires that the death certificate be Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 🗆 No been signed by the should be detached g 🗌 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death both not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 4 Unknown cate has been signated by page 2 should b 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? After this certificate 2 🗌 No 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to Be 26. Place of Death (Check only one) Hospital Other 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident injury 5 Pending work? 1 ☐ Yes 2 ☐ No M Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier License numbe 29d. Date signed (Month, Day, Year, 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 30 Year1 Month 12 8:47 A M Physician/ Angela C. Tiernan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3777 Plum Meadow Drive Ellicott City Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 213-76-2912 Director 1 □ M 2 □**X** Yrs. 52 Oct 19, 1959 PA ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2X No MD Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Numbe Funeral 3777 Plum Meadow Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. or than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No by 1 Never Married 2 X Married Specify: White If Yes, Give Year or Dates 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) i Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Retail 4 <u> Independent Consultant</u> is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Alexander Caro Colbert Rita 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai 3777 Plum Meadow Drive Ellicott City, MD 21042 Michael F. Tiernan/husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 🗌 Burial 2 🗎 🕱 remation 3 🗎 Removal from State Ardent Crem. Svc. Jan 2, 2012 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee uanita Ryhomas 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 5 years Immediate Cause (Final Physician/ disease or condition Spinocerebellar Atrophy Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) 1 Yes 2 L 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ None 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? s after death.
I Director: Aft
ed in by the fur Accident
Suicide 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 201 D0044420 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 V Marian P. LaMonte 3421 Benson Ave, Suite 240, Baltimore MD 21227

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

JAN 0 4 2012

Maryland 21215-0036

Box 68760

P.O.

Division of Vital

32. Registrar's Signature

pare

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 42234 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ DECEMBER HELEN J. TISCHA 2011 2:00 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GILCHRIST CENTER TOWSON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Hours Min 217-34-7982 1 □ M 2 🗚 F **Director** 11/24/1935 MARYLAND 76 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 1 Yes 2 X No MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 1810 TRENLEIGH ROAD 21234 USA 72 hours after death Was Deceus. Armed Forces? Ves 2 No 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Completed 3X☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 721 Department of Health and Mental Hygiene. Important: If item 27 is marked other tran "ne any injury or other traumatic event". (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 12TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 BERNARD O'BRIEN JULIA BARDEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2602 FAIRWAY DRIVE MD LINDA O'CONNOR/DAUGHTER BELAIR, 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State DUCANEY "VALLEY" MEM. 4 Donation 5 Other (Specify) **GARDENS** 12/31/2011 COCKEYSVILLE, MD 22. Name and Address of Facility The Johnson Funeral Home, P.A. MO1139 21286 8521 Loch Raven Blvd., Towson, MD 23a/Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final carcinoma of Physician/ Sauchius CEV NKHOWH disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death 5 Other (specify) been signed by the sahould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No has prior to completion of cause o director, page 2 certificate 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury injury Natural 5 Pending 2 🗌 No Accident Investigation 1 Yes completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signat and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST DWINN MD

Registrar

DHMH 17 Rev 06-2011

State

32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Margaret E. Vogel Sang 12:10PM December 20 11 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Randallstown Seasons Hospice Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) **Funeral** Hours 220-42-6464 66 1 □ M 2**X** F **Director** Yrs. 05-16-1945 Maryland 10d, Inside City Limits 28a-f show 10b County 10c. City, Town or Location aţ 10a, State Director Examiner must be notified 1 Yes 2X No MD Baltimore Randallstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 23a Funeral 21133 U.S.A. 3812 Courtleigh Drive items death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ō þ Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Linguist NSA 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Fewster Blanche Koebel be other traumatic and N 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) . Page 1 and 2 sh tment of Health a tant: If item 27 is Ronald P. Vogelsang, Sr./Husband 3812 Courtleigh Drive; Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Holy Family Church 12-31-2011 Randallstown, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Sona ure of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List orly one cause on each line Immediate Cause (Final End-stage multiple Schrosis Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death signed by the a Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed?/ ☐ Yes 2 🗹 No I or Attending Physician: The after death.

Director: After this certificate I 1 🗌 Yes 2 🗌 No 25. Was case referred to medica 26. Place of Death (Check only one) funeral director, Be examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number nshappine M.D 12/29/11 00057465

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

5 203

Backmore MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N - S RAA PARSE/M D 2835 S mr M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | | 42236 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:20 P Dale B. Wheatley Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death County of Death Coastal 125 Dice spuru comico Social Security Number 6. Sex If Under 1 Year If Under 24 birs **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 ▼ M 2 □ F Months Days Hours Min De(Conth 9 Pay, 1960 MaryTand Director 219-70-8713 50 Usual Residence of Decedent or 28a-f show 10a. State with the Maryland 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Dorchester Church Creek 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21622 USA 1903 White Haven Road death 12. Was Decedent Ever in U.S. Armed Forces?

1 🔄 Yes 2 🗆 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🗓 No Specify: white Completed 3 Widowed 4 Divorced **1**80-82 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) construction other Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Janice Elaine Webster Benjamin Henry Wheatley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Wheatley/spouse 1903 White Haven Road Church Creek, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury or 4 X Donation 5 Other (Specify) Sign Lure of Funeral Serice Licen State Add Son Board 655 W. Baltimore Street nector wi 21201 MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ Onset and Death disease or condition resulting in death) Cara Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy tor. After this certificate has been signed by the atterthe funeral director, page 2 should be detached for in the past 12 months? Pregnant at time of death 5 Other (specify) Month Yes g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autop. performed death? 1 Yes 1 Yes To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No ပ 1 Yes 1100 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) Certificate: Magner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending (Month, Day, Year) Accident Investigation 1 ☐ Yes 2 ☐ No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 63198 23/4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 066 EASTERN VOLLRA SHORE DR SACISBULY 31. Date filed (Month, Day, <sup>Year)</sup> 2012 State 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Waaner 10:15 AM 201 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Center Annapolis Medical If Under 1 Year If Under 24 Hrs. 8. Date of Birth Date of Dis. (Month, Day, Y 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F none Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director Burnie 1 🗌 Yes 2 📈 No 10f. Zip Code 10g. Citizen of What Country? 21061 Funeral 5808 USA 12. Was Decedent Ever in U.S. Armed Forces?.

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White "natural" 3 Widowed 4 Divorced any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Cinfant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H of Health and Mental H fitem 27 is marked ot Wagner Elisabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie Scott Wag Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🗓 Other (Specify) in state Signature of Funeral Service Licensee <sup>22</sup> State Anatomy Board 655 W. Baltimore Street MD 21201 Baltimore. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or havin failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final ematur Physician/ em minutes disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Fctopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death , the a been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑No 24a. Was an autopsy performed? Yes 2 No has certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural work? 1 ☐ Yes 5 Pending 2 🗌 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) (JAMI REYE 12/4/2011 D38075 s of person who completed cause of death (Item 23a) (Type, Print) Parkway Annapolis MD 2001 State

Registrar

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 42238 State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18, 2011 Physician/ 10:22 PM December Medical Frederick F. Wright 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospital Center Carroll Westminster Social Security Number . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days Min. 1 X M 2 🗆 F Months Hours Nov 8 1944 Mary land Director 67 219-54-4675 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2X No Sykesville Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21784 USA 7309 2nd Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black White etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: white If Yes Give 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 0 ticket taker movie theaters Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk injury or other traumatic 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jim Durcan/friend 1239 Stonewood Court Annapolis, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ★ Other (Specify) 21. Signature of Funeral Service Lisensee Director

State Anatomy Board 655 W.

Raltimore, MD 21201

23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22 Name and Address of Facility Board 655 W. Baltimore Street Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Cardiovascular Disecisi Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed the bunial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director: After this certificate has b autopsy performed' 25. Was case referred to medical Be 26. Place of Death (Check only one) P Other: 4/54 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

3altimore, Maryland 21215-0036

Box 68760

P.O. I

Records,

**Division of Vital** 

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31. Date filed (Month, Day, Year)

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Weilminste

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Per DVR g923 1/04/2011 JH State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Pay , Month Physician/ 2011 4:20 PMM December Mary P. Woodside Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Calvert 11450 Asbury Circle #436 Solomons 5 4 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Months 162-24-4740 Hours **Director** 1 □ M 2 👿 F Aug 17, 1929 Pennsylvania 82 Usual Residence of Decedent 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD CAlvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11450 Asbury Circle #436 20688 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give white 3 🎇 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry should be filed within 72., n and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 12 4 teacher education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk မ Charles Longwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl nt of Health a :: If item 27 is Peter M. Woodside/son 41885 Clover Hill Ct Hollywood, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Signature of Euneral Service License Ronal d 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or beart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Squamons Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a I for use as the burial-Physician/Medical yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? cate has ; Hospital or Attending Physician: The 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Hospital 2 No Other: ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After a completely filled in by the funer Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciue 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 50052242 12/21/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph J. Barth III 110 Hospital RD Ste310 Prince Frederick ,Md.

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

arneli vvynn		State of Maryland / Department of Health and Mental H	ygiene Reg.	No. 201	1 4224
Physicia	an/	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death 1335 hrs
ledical Exami		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	Month December 1	1, 2011 4c. County of Death	
		Mercy Hospital Baltimore		N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min		MM/DD/YYYY) 9. Birt Foreig	
Director		217-76-8273 12M 2 F 5/ Yrs.	Nov 26		untry) MD
any	ł	Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County           10c. City, Town or Location			10d. Inside City Limits
. i	۲	MD MA Baltimore			1 Pes 2 No
th the Maryland 23a or 28a-f sho ootified at ooce.	Director	10e. Street and Number 10f. Zip Code	10g	Citizen of What Cour	ntry?
ith the 23a or		30/9 VIORMOUNT CT 2/16  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S)	nosify Vac at Na	U. S.A.	can Indian, Black,
eath w items ust be	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		White, etc.	carringan, black,
after d	by F.	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Specify: B	lack
hours fortur fortur	ted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		6b. Kind of Business/l	ndustry
36 hin 72 e. thao '	Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)	itar	Lique	~
D 21215-0036 should be filed within 72 hours after and Mental Hygiene. 7 is marked other than "natural", natic eveot, the Medical Examiner.	S		e (First, Middle, Ma		1 . /.
2121 hould be fill and Mental F is marked rtic eveot,	Be C	To bert Coe Wynn S-  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Informant's Name/Relationship (Type, Print)	Lette V	ctutia State	Zin 2 de)
and sh	2	Charo Lette Wunn 13 Winston	4 0	elg hy	2,239
ore, MEss I and 2 stoff Health ar		20a. Met of Disposition 20b. Place o Disposition (Name of cemetery, crematory or other place)	Date :	20c. Location - City or	Town, State
Pages nent of			24,2011	Landa	un MD
Baltimore, M permit. Pages   and 2 Department of Health Important: If item 2 injury or other traus		21 Signature of Funeral Service Licensee 22. Name and Address of Facility  Remarks Grant G	SAN Fign	ral Cer	uce ma
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	or respiratory arres	t, shock, or heart	Approximate Interval
(Medical xaminer		failure. List only one cause on each ling.  Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease	se		Between Onset and Death
xammer		or condition resulting in death)  Due to (or as a consequence of):			
	Je.	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):		-	<del>                                     </del>
.0%	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Underlying Cause (C. Due to (or as a consequence of):			
executed an and al - transit		d.			
60, at be executed thysician and burial - transit	Medical	▼ UNPENDED	12 sm		
8760, tificate be ng physic as the bur		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancy	23d. Date of deliver Month	y Day <b>Y</b> ear
Box 687  e death certific  the attending p  ed for use as th	Physician/	Pregnant at time of death 5 Other (Specify)			
D.O. Box 687( that the death certifica ned by the attending pl detached for use as th	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
P.C. res that signed to be deta	d by	Cocaine Use	1 Yes	2 No 3 Pro	bably 4 🗸 Unknown
rds, requires been should	Completed		24a. Was an		utopsy findings available completion of cause of
Records The law requirecte has been a page 2 should	mo		perform 1 Yes 2	ed? death?	
Vital Reorgision: The his certificate director, page	BeC	25. Was case referred to medical examiner?  Hospital:			
Division of Vital Records, P.O. ral or Atteoding Physiciae: The law requires that the rapid redeath.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	리	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA		esidence 6 Othe	r:
teoding Pheath.	Certification:	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No			
vision Atta	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Str or Town, Sta		ural Route Number, City
Divis spital or At hours after d ocral Direct	Cer	4 Homicide determined (Specify)  29a. Certifier , Cartinian Physical Table bath for Manufacture and All States		· -	
Division of Vital Records, P.O. Box 68760, To the Hospital or Atteoding Physiciao: The law requires that the death certificate be within 24 hours after death.  To the Fuoeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred			
To viti	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	onth, Day, Year)
		Called A & O.C.M.E.		December 12, 2	011
1		30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	MD 21223		
الا 2	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature	, 1410 2 1220		
Regis		JAN 0 4 2012 June S. Janes			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 26, 2011 Physician/ 9:15 P.M Edith Gertrude Weisheit Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Min. **Director** 024-16-8936 1 🗆 M 2 🔀 F July 22, 1923 Massachusetts 88 Usual Residence of Deced 28a-f show 10a. State 10b. County be filed within 72 hours after death with the Maryland notified at Director 10c. City, Town or Location 1 Yes 2 No Maryland Harford Bel Air 10f. Zip Code ō 10g. Citizen of What Country? r items 23a or ner must be n 10e. Street and Number Funeral USA 2636 Calvary Road 21015 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status the Medical Examiner Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò Completed by 1 Never Married 2 Married 2 X No Yes If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 2 injury or other traumatic event, Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Clarisa Edith Tufts John Henry Burroughs and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 357 Rotunda Bldg., 711 W. 40th St. Baltimore, MD Bowen P. Weisheit Jr. / Son Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date emetery, crematory or other pla 1 Burial 2 X Cremation 3 Removal from State 12/29/11 Towson, Maryland Hilltop Service Corp. 4 ☐ Donation 5 ☐ Other (Specify) McComas Funeral Home, P.A. 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or se a consequence of) if any, leading to immedia cause. Enter Underlying executed use as the burial-transi Cause (Disease or injury that initiated events the attending physician and Due to (or as a consequence of) resulting in death) Last that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Dav 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by ladney Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown fibrill action 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed? Yes 2 No Hypertension after death.

Director: After this certificate 1 ☐ Yes 2 ¥No 25. Was e referred to medical examiner? of Vital 26. Place of Death (Check only one) 2 **№** No Other: Inpatient 2 ER/Outpatient 3 DOA 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending work 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year, Reduction 12/06/11

Registrar

State

31. Date filed (Month, Day, Year)

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Chesa peakl medical center

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ Dec. 2011 11:00A M David Pau1 Whetzel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1900 Maxwell Avenue Apt. Baltimore Dunda1k Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Days Hours **Director** 214-76-2279 1 🛣 M 2 🗆 F Yrs. Dec. 16,1956 Maryland 55 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Dunda1k MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be Funeral 23a 21222 United States 1900 Maxwell Avenue Apt. C items ? death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. "natural", or iten edical Examiner r Armed Forces Black, White, etc. 1 X Never Married 2 Married by Yes 2 No Maryland 21215-0036 hours after 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed er than "nature , the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) N/A 12 Years Disabled permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anna I. Kowalewski Lawrence C. Whetzel, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Plaine Pond Dundalk, MD 21222 19a. Informant's Name/Relationship (Type, Print) 8600 Sandy Plains Road Dundalk, MD Donna M. Whetzel (Sister) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Hilltop Service Corp. 12/27/2011 Towson, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw val Between Immediate Cause (Final anes Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Mcon the burial-tran and Due to (or as a consequence of) attending physician Physician/Medical Box 68760 use as IF FEMALE s, outcome of pregnancy Vive Birth 2 Fetal death Pregnant at time of death Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear 5 Other (specify) been signed by the a should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsv page 2 1 ☐ Yes 2 ☐ No Yes Division of Vital funeral director. 25. Was care referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Yes 2 🗌 No 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d Describe how injury occurred iniury work?
1 Yes 2 No 5 Pending Investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month) 29b. Signature and title of certifier 29c. License number MO 23 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Rose Gloria Wilson 201 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore City** Baltimore A anes Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 1 M 2 M Min. (Month, Day, Year) Oct 21, 1929 Months Days Hours Mass 82 027-22-3237 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location Catonsville 1 Yes 2 No **Baltimore** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A 21228 2414 Rockwell Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify Specify. 3 Widowed 4 Divorced 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Capparotta Joseph Venuto 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2414 Rockwell Ave Catonsville, MD 21228 William Affeldt Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clarksville, Maryland Jan 02, 2012 Columbia Memorial Park . Signature of Funeral Service Lice see 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 lymleden MU0535 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
ADAYS Immediate Cause (Final SEPSI disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Month Day Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown KETOACIDOSIS 24b. Were autopsy findings available ACIDOSIS 24a. Was an

Physician. Medical Examiner Examine

Physician/

Medical

10a, State

Director

Funeral

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Completed

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Examiner

Funeral

Director

show

28a-f

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23a

ural", or items?

Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examir

permit. Page 1 a
Department of H
Important: If ite
any injury or ott

Baltimore, Maryland 21215-0036

must be notified

death with the Maryland

ending physician and use as the burial-trar Hospital or Attending Physician; The law requires that the death certificate be After this certificate by the 1

Records, P.O. Box 68760

**Division of Vital** 

Physician/Medical

Completed by

Be

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Certificate:

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 1 Yes 2

autopsy performe

28d. Describe how injury occurred

prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural Accident Suicide 4 Homicide

Date of injury (Month, Day, Year) 5 Pending Investigation 6 Could not be

1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at

1 Yes 2 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other:

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifie (Check only one 29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

BALTIMORE

determined

D72741

AVENUE

201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day

900 32. Registra 's Signatur

24 hours after of Funeral Direct

within 2 To the F

completed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Wiseman **Physician** 12:35 AM Terry December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore 8. Date of Birth (Month, Day, Year) August 14,1947 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, **Funeral** 1 X M 2 □ F Months Days Hours Min. 64 205-38-6958 Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or Items 23a or 28a-f show sdical Examiner must be notified at 1 ☐ Yes 2X No Directo Joppa Harford Maryland 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21085 USA 236 Garnett Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 🎇 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White 2 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Injury or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Salvation Army Property Manager 12 years 12 should be filed w and Mental Hygier Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth E. Roland Jesse Wiseman Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health al
Important: If Item 27 Is
any Injury or other trau 236 Garnett Road, Joppa, Maryland wife Earline Wiseman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemtery 4 ☐ Donation 5 ☐ Other (Specify) 3, 2012 Dundalk, Maryland 21. Signature of Funeral Service License Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 nthon 23a. Part 1. Enter the disease of complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final small metustatic cell carcinoma **Physician** month disease or conditio resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in your light conditions, in your light cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-transit Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical law requires that the death certificate be use as the IF FEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 7 No 2□No 1 Tyes 1 Tyes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) 1 Inpatient 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA ၉ Director: After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending (Month, Day Year) investigation M 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical

Division of Vital Records, P.O. hours after To the Hospital within 24 hours a

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laura Cappell. M.O.

Lever Cappelle

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

December 24, 2011

State Registrar 31. Date filed (Month, Day, Year) **JAN 0 4 2012** 

29b. Signature and title of certifier

32. Registrar's Signature barker

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42245 For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:00aM Assaturian December Margaret М. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care - Potomac Montgomery Co. Potomac 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Country) Turkey **Funeral** 1 □ M 2 🔀 F Months Days Hours Min (Month, Day, Vrs Director October 10 578**-**56**-7**805 Usual Residence of Decedent 28a-f show 10a. State 10b, County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔽 No VA Fairfax Co. McLean 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6809 Lupine Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black White etc. "natural", or 1 Never Married 2 Married þ 2 X No Ves Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced White. Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) event, the Translator U.S. State Dept Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental F 7 is marked o ည Hapet Assaturian Nevart Assaturian other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Garo Lachinian (cousin) Shattuck Rd. Watertown. MA 02472 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 

|X Burial 2 

| Cremation 3 | Removal from State 4 | Donation 5 | Other (Specify) cemetery, crematory or other place, Parklawn Mem. Gardens 12/19/2011 Rockville, Maryland 21. Sign and of Funeral Service Licensee 22. Name and Address of Facility Murphy Falls Church Funeral Home Broad St., Falls Church, VA 22046 27a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Complications of advanced Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burial physician the burial Physician/Medical P.O. Box 68760 as attending IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Diabetes 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hupertension has autopsy performed? Yes 2 No this certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 X Yes 2 🗌 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Funeral Director: After eted filled in by the funer To the Hospital or Attending injury Natural 5 Pending 1 🗌 Yes 2 🗌 No hours after death Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier (Check 24 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Was omers D50534 December 16, 2011

Registrar
MH 17 Rev 7/2009

State

6858 Old Dominion Dr. #104, McLean, VA 22101

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas

31. Date filed (Month, Day, Yea **NFC**, **2**, **1**, **2011**  Masterson, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 12 **Physician** 12:15 A<sup>M</sup> 2011 Emma Chesley Alexander /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Clinton 9425 Michael Drive If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Min. | March 18,1926 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 1 F Months 85 220-28-7190 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23s or 28e-f show other treumstic svent, the Midical Examiner must be rectified at 1⊠Yes 2□No Clinton MD Prince George's Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 20735 United States 9425 Michael Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ĀNo If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 ☒ No Specify: Specify: Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Private Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be filk iment of Health and Mental Hytent: If item 27 is marked oth Be Mattie Swann William Chesley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9425 Michael Drive, Clinton, MD 20735 Walter Alexander, Sr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 0 = 6 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or Lincoln Memorial 12/21/2011 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licenses poce 5538 Marlboro Pike, Forestville, MD 20747 Merry 7 0108 Approximate Interval Between Onset and Death Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final zneimers vears **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) P.O. the th detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 9 Division of Vital Records. 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has 20XNo 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) 1 Inpatient ٩ ¥ Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manne of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No M death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after 24 hours a e Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ertified 12-20-11 025001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street NW # 3300 Wash DC 20001 50 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Amend#19b. Per Informant POC12-22-11cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 16, 2011 3:48 A M Andes Lucy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Mitchellville Villa Rosa Nursing Home If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number **Funeral** 7. Age (In yrs. last birthday) Days Hours (Month, Day, Year) 579-30-8405 85 **Director** 1 M 2 X X July 22, 1926 Washington, DC Usual Residence of Decedent 23a or 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 1 Yes 2XX No Maryland Upper Marlboro Prince George's 10e. Street and Number 10g. Citizen of What Country? Funeral USA 14104 Spring Branch Drive 20772 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2**x** X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 🕅 Widowed 4 🗆 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ul Hygiene. Elementary/Secondary (0-12) 12 years College (1-4 or 5+) Federal Government Budget Analyst n and Mental Hygier 7 is marked other t 18. Mother's Name (First, Middle, Maiden Surname)

Tunnita V. Bailey Be 17. Father's Name (First, Middle, Last) ည Robert Hoo1 19b. Mailing Apoless (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s if Health a item 27 i Spring Branch Dr. Upper Marlboro, MD 20772 Virginia Wyatt / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or otl
once. XX Burial 2 Cremation 3 Removal from State Suitland, Maryland 12/20/2011 Cedar Hill Cem. 5 Other (Specify) 4 Donation 22. Name and Address of Facility George P. Kalas Funeral Home PA alas 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final Ph\_sician/ ACUTE MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events the burial-tran and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed . Were autopsy findings available prior to completion of cause of page 2 autopsy perform death? certificate 2  $\square$  No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 💆 No 1 Xes ျ 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manher of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury after death. 1 Yes 2 No filled in by the Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Fractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 29d. Date signed (Month, Day, Year) 12-16-2011 D32261 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LANHAM, WD 2004 -Eldman Goodlick Rd Kichman W 8/16 32. Registar's Sign DEC 2 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42248 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1:17 A M Edna н. Agnew 2.011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hospice Salisbur at the 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. (Month, Day, Year) 577-22-1689 **Director** 1 🗆 M 2 😾 F 88 01/27/1923 Dist. of Columbia 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 351 Deers Head Hospital Road 21801 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Secretary Medical Field Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Joseph Lester Hall Viola Meade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Darla N. Morres / Daughter P.O. Box 291, Washington, VA 22747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Parsell Funeral Homes 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/13/2011 🗞 Crematorium <sup>22</sup> Name and Address of Facility <sup>22</sup> Parsell Funeral Homes & Crematorium Parsell Funeral Homes & Crematorium Parsell Funeral Homes & Crematorium Part 1. Enter the di se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, i.e. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart and Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ s been signer should be c 1 Yes 2 No 3 Probably 4 WUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed certificate 2 No 1 Ves filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မ patient 2 ER/Outpatient 3 DOA 1 1 W this Manne Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After L atural 5 Pending work? 1 Yes 2 No s after death. Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Date filed (Month, Day, Year)

MY S(HORE DK, SAUSBURY NO 21804

cause of death (Item 23a) (Type, Print)

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Physician/ 1900 Robert Adams 2011 Peter Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Wicomico 7402 Forest Plains Lane Salisbury 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Birthpic Country) York 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Days (Month, Day, Yea 3-7-1950 1 X M 2 □ F Months Hours Min Yrs 216-56-1681 Director New 61 Usual Residence of Decedent items 23a or 28a-f show ier must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 1 🗌 Yes 2 🔀 No MD Wicomico Salisbury 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 7402 Forest Plains Lane 21804 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 Married ,0 þ within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: White "natural" 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene.

27 is marked other than "r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) 11 Painter Construction Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ance. ပ Robert Samue1 Adams Evelyn Annabelle Kirchner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn E. Adams - Sister 32120 Morris Leonard Road, Parsonsburg, MD 21849 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Springhill Memory Gd. 12-15-2011 Hebron, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bounds Funeral Home Salisbury, Maryland 21804 705 E. Main Street, 23a. Part 1. Enter the disease, or compositions, or heart failure. List only of tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ASCND Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) executed Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IE FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ò Month Dav Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No page 2 s has 1 Yes 2 No certificate 25. Was case referred to medica director. 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 🗆 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 A Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one 29b. Signature a 29d. Date signed (Month, Day, Year) 12/13/11 H50497 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salishu 21801 hns E Carroll St

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MSEC 201°1 Physician/ ARVIN JR. 6:05 PM **GEORGE** HOLLIS Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** WORCESTER FRIENDSHIP GARDENS BERLIN 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral 1 XX 2 □ F Days Hours Year 1932 Months JUNE 13 WEST VIRGINIA 79 Director 232-32-7344 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🛣 No SELBYVILLE SUSSEX DELAWARE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 19975 USA 36847 WEST POND CIRCLE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No Black, White, etc. by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates. 1951-55 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DEPT. HEALTH & HUMAN MANAGEMENT ANALYST SERVICES Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nd Mental I ည ARVIN THELMA LAWRENCE SR. **GEORGE** Η. .. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36847 WEST POND CIRCLE, SELBYVILLE, DE. 19975 BETTY L. ARVIN/WIFE or other Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State DELMAR, DELAWARE 12/14/11 4 Donation 5 Other (Specify) CREMATORY OF DELMARVA 22. Name and Address of Facility 21. Signature of Juneral Service Licens HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying ne Due to or as a conse quence of: Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month for Pregnant at time of death 5 Other (specify) Yes 2 No the be detached 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed page this certificate 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. examiner? Hospital Other: 2 No 4 Nursing Home 은 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27 Manner of Dath 28b. Time of 28c. Injury at Certificate: After injury 5 Pending work Natural after death. Director: Af 1 🗌 Yes 2 🗌 No Accident Investigation the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by ☐ Homicide 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check edge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practions within 2 To the I only one

State

DHMH 17 Rev 7/2009

Registrar

Registrar's Sign

11-09468 Hazel I Amold

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

azel L. Arnold	State of Maryland / Departr	nent of Health and Mental I cate of Death	Hygiene 201	1 4225						
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last)  Hazel Louise Arn	old	2. Date of Death Month Day Year December 16, 2011	3. Time of Death 1817 hrs						
	4a. Facility Name (if not institution, give street and number) Western Maryland Health System	4b. City, Town, or Location of Dea Cumberland	_1	h						
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday)   If Under 1 Year   If Under 24F   Months   Days   Hours   M	in. Foreig	rthplace (State or gnMaryland ountry)						
v any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow	n or Location	112/00/1910	10d. Inside City Limits						
vith the Maryland  23a or 28a-f show  notified at once.  al Director	10e. Street and Number	Imberland  10f. Zip Code	10g. Citizen of What Cou	1 X Yes 2 No						
r death with the or items 23s or must be notifie	227 Humbird Street  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	21502  13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer		rican Indian, Black,						
s after deat ral", or ite niner must	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year of Dates:	1 Yes 2 No specify:	Specify: Wh	ite						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use r Homemaker		ilidusii y						
21215-0036 2uld be filed within 7   Mental Hygiene,   marked other than   cevent, the Medica   To Be Comple		ong, Sr. Floren	ne (First, Middle, Maiden Surname) ce Frances	Redhead						
MD 21 d 2 should lth and Me n 27 is ma numatic ev	19a. Informant's Name/Relationship (Type, Print)  Albert F. Long, Jr. / Brother	9b. Mailing Address (Street and Number of 12613 Limestone Road								
Baltimore, Nemit Pages I and Department of Health Important: If item injury or other trau	20a Method of Disposition 20b. Place 1 N Burial 2 Cremation 3 Removal from State crem	e of Disposition (Name of cemetery, atory or other place)	Date 20c. Location - City or /20/2011 Greenspri	Town, State						
Baltir permit. P Departme Importan injury on	21 Signature of Funeral Service Licensee	I	dams Family Funeral et, Cumberland, MD	Home, P.A. 21502						
Physician Medical Examiner	De to Time the disease, or complications that caused the death. Do failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Injuries	not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death						
* <sup>/</sup>	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.									
ted Insit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
and tra	d amended									
box 68760, the death certificate be exc by the attending physician ched for use as the burial Physician/Medic:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnance 1 Live birth 4 Pregnant at time of death	2 Fetal death 3 Ectopic preg	nancy 23d. Date of deliver	y Day Year						
Box he death y the atterhed for u	1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not result		e given in Part I. 23e. Did tobacco use contribute to the cause of death?							
s, P.O. uires that th n signed by Id be detach	Takin Sulai Sigini Gan Soliali Silai Soliali Sulai Sul	ing in the discentifing cause given in Fact.	1 Yes 2 No 3 Pro	bably 4 Unknown						
Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Me				utopsy findings available completion of cause of es 2 No						
fital Resistant The sician: The is certificate lirector, page	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FEV	26.Place of Death (Chec	k only one) sing Home 5 Residence 6 Othe	r:						
on of Viending Physiath.  or: After this he funeral direction: To	27. Manner of Death  1 Natural 5 Pending Dec 16, 2011  1 Natural 5 Pending Dec 16, 2011	b. Time of Injury 28c. Injury at Work? 36 hrs 1 Yes 2 ✓ No	28d. Describe how injury occurred Pedestiran struck by auto							
Division or To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune edical Certification:	2 Accident investigation   28e. Place of Injury - At home, farm, street, factory, office building, etc.   28f. Location (Street and Number or Rura or Town, State)   4 Homicide   4 Homicid									
To the Host within 24 hc To the Fun completely f	29a. Certifier 1 Certifying Physician: To the best of my knowledge, done) 2 Medical Examiner: On the basis of examination and/or									
F. Surative	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Mo							
nes	30. Name and address of person who completed cause of death (Item 23a Jack Titus MD. Deputy Chief Medical Examiner		e, MD 21223							
State Registrar	31. Date filed (Manth Pay Year) 2011 32 Registrar's Signature	- sullad								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42252 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <sup>Month</sup>ec 13. 2011 Year 2245 Aronhalt Alice Dorothy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Prince Frederick Calvert Memorial Hospital Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Months Hours Min. Yun 18, 91918 **Director** 214-12-3049 93 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director WV Hampshire Romney 1 XYes 2 No 10f. Zip Code 10e. Street and Number permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be n 10g. Citizen of What Country? Funeral USA 545 3rd Street 26757 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes; specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: Completed 3 XVidowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene. 77 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Law Firm legal secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Alice Engle Harry Gilbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1425 Solomons Island Rd. N Prince Frederick MD 20678 Bette Bowen daughte Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Rocky Gap Veterans Cemetery 12/19/20 Flintstone MD 4 ☐ Donation 5 ☐ Other (Specify) ature o Funeral Service 22. Name an Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) a. COMPLICATIONS F 42 Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami and I-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a sthe burial-1 Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s performed? Yes 2 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 340 ျ 1 🗌 Yes 1 Inpatient 2 DER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 1 Natural (Month, Day, Year) injury 5 Pending work 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral E Hospital Medical 29a. Certifier Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

St. Ca

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:35 Physician/ November 26, 2011 Рм Charles Martin Andrews Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick College View Center Social Security Number 7. Age (In yrs. last birthday) If Unde Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year) 213-92-6783 48 **Director** 1X M 2 □ F Nov. 14, 1963 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits notified at Director MD Frederick 1 XYes 2 ☐ No Frederick 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? must be Funeral items 23a 37 E. 4th Street 21701 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. 1 X Never Married 2 ☐ Married ō þ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates White Specify: "natural" Completed 3 Widowed 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Labor Work Construction Be other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Martin Andrews Sr. Darlene Louise Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shi Department of Health ar Important: If item 27 is any injury or other trau once. (Brother) 9201 B Catoctin Mountain Highway, Frederick, MD 21701 Frank Andrews 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 11/30/2011 Manor Cemetery Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Reeney & Basford P.A. Funeral Home 106 Fast Church St., Frederick, Maryland 21701 MO1612 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ 10dder disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions Examiner Due to for as a consequence of) cause. Enter Underlying Cause (Disease or injury been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 1 Yes 2 L 9 Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner eath 28a. Date of injury (Month, Day, Year) 28b . Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation

the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) December 27,2011 604 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chrisan + redfrick 65

28f. Location (Street and Number or Rural Route Number,

State Registrar 3 ☐ Suicide 4 ☐ Homicide

6 Could not be

3

determined

5

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 3. Time of Death 3:42 P 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 24, 2011 Physician/ Bailey Hall Bryner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Braddock Heights Vindobona Nursing Home Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Jan. 1924 Pennsylvania 191-18-9224 87 1 🔀 M 2 🗆 F Director Usual Residence of Deceden 28a-f show 10d. Inside City Limits notified at 10a. State 10c. City. Town or Location Director 1 🗆 Yes 2 🄀 No Frederick Frederick MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be r Funeral 21703 United States 4316 Basford Road items 2 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. ed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1942-1946 1 Yes 2 No Specify. Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) US Government permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other tany injury or other traumatic event, the once. Engineer Be 18. Mother's Name (First, Middle, Maiden Surname)
Leah Hall 17. Father's Name (First, Middle, Last) ဂ္ Jesse James Bryner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 5730 Crestridge Ct., Frederick, Maryland 21703 Nelson Bryner Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery crematory or other place)
Smithsburg Crematory 12/27/2011 1 Burial 2 K Cremation 3 Removal from State Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Keeney & Basford P.A. Funeral Home 106 E. Church Street, Frederick, MD 21701 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ semento disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical ul or Attending Physician: The law requires that the death certificate beather death.

Director: After this certificate has been signed by the attending physicis Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 Tyes ည 1 Inpatient 2 ER/Outpatient 3 DOA sing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 \sum Yes 2 \sum No Investigation Accident Accider
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours Hospital Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MO

DHMH 17 Rev 06-2011

State

Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month DEC Physician/ Day MARILYN BOCCUCCI 7:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOMEWOOD AT WILLIAMSPORT WILLIAMSPORT WASHINGTON If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months 1 🗆 M 2 👿 F Hours 2/8/1930 VIRGINIA 228-30-3507 **Director** 81 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location death with the Maryland Examiner must be notified at 10d. Inside City Limits Director W٧ BERKELEY FALLING WATERS 1 Yes 2 X No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 45 HUMPHREY LANE 25419 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, o, þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: "natural", Specify: WHITE Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be flik Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve LAWRENCE ALBERT THEODORE MIRIAM CANTOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARIE NICOL 707 COLSTON DRIVE, FALLING WATERS, WV 25419 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State FATTING WATERS PRESE. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FALLING WATERS, WV 2011 Signature of Funeral Service License 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, Mobe 327 W. KING ST., MARTINSBURG, WV 25402 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ PARKWSOVIS BISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the buria by Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 month Month 9 Unknown detached 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed KIDVEY 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? AVENIA 24a. Was an autopsy performed? After this certificate 1 Yes 2 No Yes 2 funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completed filled in by the fi 1 ☐ Yes 2 ☐ No Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) in mo 100 P0018019 PECEMBER 21, 2011 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 340 m.11 AREKSTOW P 32. Registrary Signat State Registrar

11-08890

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

rica L. Bivens		State of Maryland / Department of Health and Menta  - For State Certificate of Death  Registrar		ZUI leg. No.	1 4225				
Physician/ ' -ical Examiner		Decedent's Name (First, Middle,Last)	2. Date of Dea	ath Day Year er 25, 2011	3. Time of Death 1459 hrs				
		Eric A Louise Bivens  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of D		4c. County of Death					
		Johns Hopkins Medical Center Baltimore		Baltimore					
Funeral Director		5. Social Security Number 2 2 0 - 8 5 - 5 1 2 9  1 M 2 X F  7. Age (In yrs. last birthday)   If Under 1 Year   If Under 2   Months   Days   Hours    Yrs.	Min. 10/23/	irth(MM/DD/YYYY) 9. Bir Foreig 2009	thplace (State or In In In In In In In In In In In In In				
any	ŀ	Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County			10d. Inside City Limits				
	2	Maryland Baltimore City Baltimore			1 X Yes 2 No				
ith the Maryland 23a nr 28a-f show notified at once.	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	ntry?				
ith the 23s nr		1929 W. North Avenue 21217  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	? ( Specify Yes or N	USA	can Indian, Black,				
eath w	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	uerto Rican, etc.)	White, etc.					
after d	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Specify: Black					
hours natur		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kin during most of working life. DO NOT us		16b. Kind of Business/	Industry				
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5-0( iled wi Hygier Inther		The first state (First, Indeed, 2005)	Name (First, Middle,						
Baltimore, MD 21215-0036 permit, Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked after than "natural", or items 23a nr 28a-f she injury or atther traumatte event, the Medical Examiner must be notified at once	To Be	Eric L. Bivens Tierra  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number	Johnson er or Rural Route Nu	imber, City or Town, State	, Zip Code)				
MD 12 shouth and 12 shounties	-1	Tierra Johnson/mother 303 S. Camden Ave.,							
s 1 and s 1 and f Healt		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State				
Baltimore, permit, Pages I ar Department of Her Important: If ite injury or nither tr		4 Donation 5 Other Specify: Asbury UMC Cemetery 1	2/15/2011	Nanticoke,	Maryland				
Ball permit Depart Import	d	1. lignature of Funeral Service Lice see 22. Name and Address of Facility  JOLLEY MEMORIA			alisbury, MD 21801				
Physician	٦	23a. Part I. Enter the disease, or complications that cau, d the death. Do not enter the mode of dying, such as care failure. List only one cause on each line. Dehydration complicating seizur	diac or respiratory at	rest, shock, or heart er, acute and	Approximate Interval Setween Onset and				
)/Medical Examiner		Immediate Cause (Final disease e.chronic lung disease, and cardiomega	aly		Death				
		or condition resulting in death)  Due to (or as a consequence of):  b.							
	miner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause							
	Exam	(Disease or injury that initiated events resulting in death) Last							
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60, te be execut hysician and e burial - tra	Medical	IF FEMALE: 23a, 2/, per me, g925 3-15-12 s		23d. Date of deliver	<u> </u>				
OX 6876 eath certificat attending phy for use as the	clan/h	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic p	regnancy		Day Year				
Box 687( e death certifica the attending pl ed for use as th	Physic	4 Pregnant at time of death 5 Other (Specify) 9 Unknown							
c d b d	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part		tobacco use contribute to	_				
ords, P.C.  v requires that s been signed should be dete	be d				utopsy findings available				
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sted in by the funeral director, page 2 should!	Completed		auto	opsy prior to ormed? death?	completion of cause of				
tal Rec		25. Was case referred to medical 26.Place of Death (C		2 No 1 Y	es 2 No				
Vita hysician this cer	o Be	evaminer?		Residence 6 Othe	r:				
ing Ph	٦	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?		how injury occurred					
Sior Attend Attend r death. ector: by the	catic	2 Accident Investigation 28e Place of Injury At home farm street factory office building etc.		(Street and Number or Re	ural Route Number, City				
Divi	Certification:	Suicide 6 Could not be determined (Specify)  Suicide 6 Could not be determined (Specify)							
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	- 1	29a. Certifier (Check only one)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place one)	e, and due to the car	use(s) and manner as sta e and place, and due to th	ted. ne cause(s)				
To t com	Medical	29b. Signature and title of certifier 29c. License number		29d. Date signed (Md					
		O.C.M.E.		November 26, 2	011				
ļ		30. Name and address of person who completed Suse of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltim	nore. MD 2122:	3					
St	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	, = 1==						
Regist		DEC 15 2011 Que a garage		• 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month Year DSAM Physician/ Broad 12 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomer 0 05 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday, Social Security Number **Funeral** May 22, 1 □ M 2 🔀 F Months Hours <sup>Year)</sup>92<u>6</u> South Carolina **Director** 247-32-3926 85 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Md. P.G. Forestville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 6625 Merritt Street 20747 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: Black Completed 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping Attendant U.S. Senate 9th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Page 1 and 2 should be ment of Health and Menta George Bridges Lina Mance 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) David Butler - Son 6625 Merritt St., Forestville, Md. 20747 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Washington Nat'l Cem 12-28-11 4 Donation 5 Other (Specify) Suitland, Maryland 22. Name and Address of Facility Ronald Taylor II Fueral Home Signatur Funeral Service Licen D Md. 20695 10583 Middleport Lane, White Plains. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Sepsis Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Week Examiner Sequentially list conditions, it any, leading to in hediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? signed by the atte Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Records. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 ☐ Yes 2 No this certificate 25. Was case referred to medical examiner? Division of Vital or Attending Physician: 26. Place of Death (Check only one) director, Be 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည within 24 hours after deau.

To the Funeral Director. After th funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Certificate: 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

old

32. Registrar Signature

(Teorgetown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:45 Robert Thomas Bonham Ϊ8, 2011 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Riderwood Village Montgomery Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 1 X M 2 | F Months Days Hours 318-16-2038 September 10,1924 Baltimore, Maryland 87 Yrs Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director notified 28a-f 1 🗌 Yes 2 🔀 No Maryland Montgomery Silver Spring 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ,s 23a o<sub>n</sub> r must b Funeral 20904 3160 Gracefield Road, #OG-3139 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 🔀 Yes 2 🗌 No NAVY Black, White, etc. ō ģ 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Farst if then 27 is marked other than "natural", or uny or other traumatic event, the Medical Examinury or other traumatic event, the Medical Examinury. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1943–1946 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Legal Attorney 5+ ed other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ Robert Thomas Bonham Bertha Stoltenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3116 Gracefield Rd., T-04, Silver Spring, MD 20904 / Wife Jean W. Morgan-Bonham 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If its any injury or of cemetery, crematory or other place) ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 12/19/2011 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. PAG Pagers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovascular Accident Physician/ Hour disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cerebrovascular Disease Sequentially list conditions Examine Due to for as a consequence of if any, reading to immedicause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year 5 Other (specify) Month Day Pregnant at time of death signed by the at d be detached for Unknown Hospital or Attending Physician: The law requires that the c24 hours after death.
 Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s Yes 2 X No 1 Yes 2 No 25. Was case referred to medica Be funeral director, 26. Place of Death (Check only one) Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital ၉ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred X Natural 5 Pending iniury Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and titl 29d. Date signed (Month, Day, Year) 29c. License number

12+1

31. Date filed (Month, Day, Year) State Registrar

M.D., 3110 Gracefield Rd., Silver Spring, MD 20904 Mark A. Parkhurst, 32. Registra Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D24093

12/19/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH 6924 2/13/2012 JH State of Maryland 7 Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death L. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 14 Year ha 0 De 11:25 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care Pineview Nursing Home
6. Sex 7. Age (In yrs. last birthday) If Prince Georges Clinton 8. Date of Birth If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 58 If Under 1 Year Funeral 1 □ M 2 K F Months Days Hours (Month, Day, Year) 577-46-9<del>438</del> Yrs. **Director** 76 March 7 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 X Yes 2 No DC Washington 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2941 W St., SE 20020 United States items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. o, þ 1 Never Married 2X Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify:Black Completed "natural" 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DC Parks & Recreation Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John McCord <u>Lillie Price</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2941 W St., SE Washington, DC 20020 19a. Informant's Name/Relationship (Type, Print) Ernest Bell/husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 12/22711 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Wa<u>shington Nat.</u> Cemetery Suitland. 22. Name and Address of Facility Hodges ure of Funeral Service Licensee & Edwards F.H. 3910 Silver Hill Rd., MD.20746 Suitland, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death ₽hysician/ hronic Kena disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical P.O. Box 68760 signed by the attending place as detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death\_but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Respiratory Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed plnous 24b. Were autopsy findings available SM 24a Was an autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No page 2 s this certificate has Disorder 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 ☐ Yes 2 ☑ No ၀ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 24 hours after death.
Funeral Director: After 5 Pending iniury 1 Natural Accident Investigation completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature 29c. License number 29d, Date signed (Month, Dav. Year) 15 2011 DDS3337 ecember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 203 ८ 200 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 76, 2011 5:00 Ам Willa Barnes Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Gentle Steps Assisted Living Riverdale If Under 1 Year If Under 24 Hrs. Months Days Hours Min. **Funeral** Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Month, Day, Yo Year 1925 North Carolina Director 86 Jan. 248-88-7142 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Rock Hill SC York 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 507 Oates Street 29730 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural", Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Retail Sales Associate Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ild be file Mental F ပ Willie Simpson Angeline Graham should and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 3726 Jenifer Street NW Washington, DC Doris M. Barnes - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place)
Grandview
Memorial Gardens Dec. 21 4 ☐ Donation 5 ☐ Other (Specify) 201122. Name and Address of Facility 21. Signature of Funeral Service Licensee Stewart Funeral Home, Inc. Washington, DC 20019 4001 Benning Road NE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ demention disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant :
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has by page 2 s autopsy or Attending Physician: The performed' 2 31 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted Living
4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo Other: ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending 24 hours after death. Funeral Director; A 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Hospital Medical Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29c License number 29d. Date signed (Month. Day, Year) December 16, 2011 D25001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jay H. Lippman, MD, FACP 9200 Basil Court Suite 200 Largo, Maryland

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

of Vital

Division

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ December 13, 2011 Barbara Ann Green Banks 1644 hrsM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges Hospital Center Cheverly Prince Georges Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year)1940 Months Hours 71 **Director** 578-52-8226 1 □ M 2**X** F January 28, North Carolina Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d Inside City Limits Director 1 Yes 2X No Maryland | Prince Georges Hyattsville 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ian "natural", or items 23a or Medical Examiner must be Funeral 3557 - 55th Avenue; Apt. 2 20784 United States death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: **Black** Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 ral Hygiene. Pat Arnolds Tall life. DO NOT use retired) ntary/Secondary (0-12) College (1-4 or 5+) the Girls Shop 12th grade Clothes Buyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o မ permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Benjamin Green Benzie Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Cannon-Bey (Brother) 5513 Ruxton Drive; Lanham, Maryland 20706 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State Dec.20,2011 Glenwood Cemetery Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) Signatur f Funeral Ser 22 Manual Address of Facility R. N. Horton Company Morticians, Janvie Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CARDIAC Physician FATAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No 9 Unknown Unknown P.O. | signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 V No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: \_ 2 💢 No 1 Yes 1 Inpatient 2 K ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After t 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death. I Director: A Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide determined within 24 hours a

To the Funeral C

completely filled Medical

State

DHMH 17 Rev 06-2011

29a, Certifier (Check

only one) 29b. Signature and title of

31. Date filed (Month

3 =

DR.M. SATTARIAN

Certifying Nurse Practition

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

HUSSITAL DRIVE

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D00653107

the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

CHEVERLY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42262 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 13, 2011 Physician/ Ernestine Baker 7:58A<sup>M</sup> Medical December 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince Georges If Under 2 Hours Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛣 F Months Days Min (Month, Day, Year) March 3, NC **Director** 239-48-6410 70 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PG Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1746 Countrywood Court 20785 United States death v 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 72 hours after þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify Specify: 3X Widowed 4 □ Divorced Completed Year or Dates Black other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 10 Private Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic. Norfleet Pippen Jr Carrie Dancy 19a. Informant's Name/Relationship (Type, Print) o. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 914 West Wilson Street arboro, NC 27886 Clayton Pippen/son Tarboro, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 12/1<sup>D</sup>9<sup>te</sup>/11 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Heritage Memorial Cemetery Waldorf, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD.20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ateriosclerotic Contiovascular disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to lar all a consequency of requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-t Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ signt be o hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Dyslipsdemia 24a. Was an page 2 autopsy performed 1 Yes 2 No 1 Yes **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) ျှင် 1 🗆 Yes 2 No Other: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann f Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 24 hours after death Funeral Director: A Accident Investigation 6 Could not be filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed (Check within 2 To the I 3 🗆 Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5 341 2011 Shesadn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14 300 FUX Gallan 20715 210 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Miquel Angel Balea 2011 8:57 December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1328 Aspen Drive Salisbury Wicomico Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Months Days 220-90-9384 Director 1 X M 2 - F Yrs 45 Tennessee 08/22/1966 Usual Residence of Decedent 28a-f show 10b. County any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Ves 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1408 Toadvine Road 21804 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married <u>Ş</u> Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Deaf Independent (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Living Association Chief Financial Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Orlando Antonio Balea Adelfa Guillermina Serra permit. Page 1 and 2 should the Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ingrid H. Balea/spouse 1408 Toadvine Rd., Salisbury, MD 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 12/19/2011 Salisbury, MD Signature of Funeral Service Licensee HolToway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 A Domisson CESP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final self inflated Physician/ gunstrot woul disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami requires that the death certificate be executed ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 for use a 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign. þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has b autopsy perform 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 12/12/11 1 Yes 2 No 0830 GSW head Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1528 Aspen Dr. Sawby determined Sawbry Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check C hitying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 100 E caroll St Salake MO 2 1801 Юo DIME 31. Date filed (Month

DHMH 17 Rev 06-2011

State Registrar

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			partment of Health and Menta				
		Registrar  1. Decadent's Name (First, Middle, Last)	ertificate of Death	Reg. No. 20   42264			
Physici: Medi		Robert Lee Bailout	Mor				
Exami		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
. /		ISEMIN NOVISING HOME Healthway Dr	If Under 1 Year   If Under 24 Hrs.   8 Date	Worcester			
Funeral Director		5. Social Security Number  3.0 48 1617  Usual Residence of Decedent	Months Days Hours Min. (Months Days Hours Min.	e of Birth nth, Day, Year)  9. Birthplace (State or Foreign Country)  Virginia			
Maryland 28a-f show notified at	Director	10a. State 10b. County 10c. City, Town or Lo Maryland Worcester 5now 1		10d. Inside City Limits 1 ☑ Yes 2 ☐ No			
with the h 23a or 2 ust be no	Funeral Di	10e. Street and Number 111 Gunby Street	10f. Zip Code 21863	10g. Citizen of What Country? United States of America			
I e, INIAL VICILIO Z IZ ID-UUJO I and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	Be Completed by Fun	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No  If Yes, Give  Year or Dates,	or No- tc.)  14. Race - American Indian, Black, White, etc.  Specify: Slack				
2-003 2 hours aft "natural", adical Exar			dent's Usual Occupation kind of work done during most of working	16b. Kind of Business Industry			
mit. Page 1 and 2 should be filed within 72 hours after ppartment of Health and Mental Hygiene. portant: If item 27 is marked other than "natural", o y injury or other traumatic event, the Medical Exam Ce.		Elementary/Seconday (0-12) College (1-4 or 5+) life. D	OO NOT use retired)	Restourant			
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should and Me		19a. Informant's Name/Relationship (Type, Print), 19b. Maill	ing Address (Street and Number or Rural Poute I	Number, City or Town, State, Zip Code)			
1 and 2 so if Health a item 27 i		Pansy Bailey/Daughter P.	O.Box 651 Berl	A 4.6			
. 0			matory or other place)	20c. Location - City or Town, State			
permit. Page Department. Important: I any injury or		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Dec 17-2  2. Name and Address of Facility Dobosom				
limp perm		Name & Marris	2. Name and Address of Facility Decord	th Harris Nock Funeral Han			
Physician/ Medical		23a. Part 1 Enter the disease, or complications that caused the death. Do not ent shoot or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of):	er the mode of dying, such as cardiac or resp	Approximate Interval Between Onset and Death			
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ed rsit	Examiner	If any bearing to in modest cause. Enter Underlying Cause (Disease or linjury		9-201_			
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2 38 3	omplet			a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?			
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ding I th. After funer	cate	27. Manner of Death  1 X Natural 5 □ Pending 2 □ Accident Investigation  28a. Date of injury (Month, Day, Year)  injury	cribe how injury occurred				
l or Attendi after death Director: A I in by the fi	Certificate:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, streething building, etc. (Specify)		ation (Street and Number or Rural Route Number, or Town, State)			
To the Hospital or Attending Physician: The lawithin 24 hours after death.  To the Funeral Director: After this certificate hompleted filled in by the funeral director, page	Medical	29a. Certifier (Check only one)  1 ★ Certifying Physician: To the best of my knowledge, death of the control of the control one)  1 ★ Certifying Physician: To the best of my knowledge, only one)	date and place, and due to the cause(s) and manner stated.				
4		Mohan	D 29349	December 13, 2011			
200		30. Name and address of person who completed cause of death (Item 23a) (Type, F William H. Robins, MD, 9715 Hea	althway Dr, Berlin	, MD 21811			
Stat	е	31. Date filed (Month, Day, Year)  32. Registrar's Signatur	me				

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day 4 2011 Agnes Koller Bassford Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 611 Tressler Dr., Suite 303 Salisbury Wicomico 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) **Director** 213-22-0764 1 □ M 2 🗶 F 86 05 27 1925 MD show 10a. State at 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f MD Wicomico 1 X Yes 2 No Salisbury 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or Funeral 611 Tressler Dr., Suite 303 21801 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 ₺ Widowed 4 □ Divorced Completed White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any niury or other traumatic event, the Medical one. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Banking NationAL Bk. of Wash. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wenzel Koller Mary Koller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen L. Bassford 1105 Harbor Point Dr. Salisbury, MD, 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) St. Mary's Piscat. Cem. 12|9|2011|Clinton, MD 22. Name and Address of Facility Holloway Funeral Home P.A. dure of Funeral Service Licensee avid 7 CESP Snow Hill Rd., Salisbury, MD, 21804 Hompson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ vehovo disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) death certificate be executed use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Pregnant at time of death Month Day Year signed by the a ld be detached for the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed 2 🗌 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 9 No ပ 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Man of Death Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural work hours after death. 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 No Investigation 24 hours after death e Funeral Director. filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one) within 7 29d. Date signed (Month. Day, Year, DUSOL son who completed cause of death (Item 23a) (Type, Print) of p 30. Name and addres Sit 101 31. Date filed (Mont) State 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gertrude Gladys Burress Month d Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Western MD Regional Medical Center Cumberland Allegany 5, Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Days Hours 04911271943 1 □ M 2 🛣 F 68 Virginia Director 230-62-8131 Usual Residence of Decedent 28a-f shov 10b. County ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Flintstone 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21501 National Highway, NE 21530 USA death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Completed by within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: than "natural", Specify: 3 Widowed 4 Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) None Disabled marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
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Stump is marked o ျှ Burress James Robert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21501 National Highway, NE, Flintstone, MD Helen Clites / Sister permit. Page 1 and 2 sh Department of Health a Important; If item 27 is 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or Grandview Memory Gardens 12/20/2011 Bluefield, VA 22. Name and Address of Facility Adams Family Funeral Home, F.A. ignature of Funeral Service Licenses any 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each, line Immediate Cause (Final Onset and Death Physician/ Kenal disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 2 weeks seps 15 Sequentially list conditions cause. Enter Underlying Exami Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed -tran and Due to (or as a consequence of) inding physician a use as the burial-t Physician/Medical P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ō Day Month Year Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed death? 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No Certificate: To 1 ♣ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Lacertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [ Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29d Date signed (Month, Day, Year) 29c, License number ms 1)0033280

Registrar

State

31. Date filed (Month, Day, Year DEC 19 625 Kent Avenue, Cumberland, MD

21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sunil K. Gupta, M.D., 625 Kent Ave

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42267 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Day Year 8:26 PM ois LEE CURRAN 102 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Agres Hospital Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number '. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 M 2 F Hours (Month, Day, Year Months Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral **Z11** Z Z 15 BROOKFIELD RD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 ₩idowed 4 ☐ Divorced Specify: WhITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) INDA ( 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 12-22-1 JANERTY FUNEAR HOME 100942+260(MOUNTAIN RD. PASADIE cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Part 1. Enter the disease, or co shock, or heart failure. List only Approximate Interval Between Associated Preumonia Inset and Death Immediate Cause (Final Health Physician/ Care days disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Uro sepsis Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a Jonsequence of): The law requires that the death certificate be executed -transit and Due to (or as a consequence of) resulting in death) Last the attending physician a the for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Dav Year been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? 1 Yes 2 No Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a To the Funeral D Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)  $\mathbb{C}.\mathcal{M}$ Hlaing 2406 2011 m December 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21229 Caton HLAING TINT 900 Hvenue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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42268

Year

Registrar DHMH 17 Rev 06-2011

State

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PM Patricia Ann Cromer 6:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oasta isbur icomeco If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Virginia **Funeral** 1 🗆 M 2 🔀 F **Director** 214-60-9071 60 Yrs. March 16, 1951 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico Delmar 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 916 E. State Street Apt. 27 21875 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 K Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 relay worker manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald Junior Strouth Department of Health and Men Important: If item 27 is marke any injury or other traumatic Lucy Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Candie Renee Nelson (Daughter) 9323 Colonial Mill Drive Delmar, MD Baltimore, N 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12-6-2011 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State Springhill Memory Gardens 4 Donation 5 Other (Specify) Hebron, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 E. Grove Street Ment Delmar, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Carcino Medical Due to or as a consequence of): **Examiner** Sequentially list conditions. Examine Due to for as a consequence of: cause. Enter Underlying for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed eral Director: After this certificate filled in by the funeral director, pag 1 Yes & No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence & Other (Specify) H Sh 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred the last Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D (3199 12/3/11 ddless of person who completed cause of death (Item 23a) (Type, Print) YUG 910 ENSTERN VOHRA SHOPE DR. SALISBULY MD 21804 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DEC -13 2011 PATRICK WARREN CARLIN 2:50 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY CASEY HOUSE HOSPICE ROCKVILLE Birthplace (State or Foreign Country) **Funeral** Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Hours **Director** 212-64-9886 1 M 2 D F 59 WASH., DC 06/05/1952 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🗹 No MD MONTGOMERY GERMANTOWN 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20874 20016 WAYNEGARDEN CT. USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) , or Black, White, etc. 1 Dyever Married 2 D Married Yes 2 No by Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", 3 ☑ Widowed 4 ☐ Divorced Specify: WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) than MONTGOMERY COUNTY Elementary/Secondary (0-12) College (1-4 or 5+) SECURITY PUBLIC SCHOOLS is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည HUBERT L. CARLIN EMILY BURROW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau THOMAS CARLIN / SON 11427 SCHUYLKILL RD., ROCKVILLE, MD 20852 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) STAUFFER CREMATORY 12/14/2011 FREDERICK, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility P.O. BOX 86 M HILTON FUNERAL HOME BARNESVILLE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition PROSTATE CANCER Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that initiated events -trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FFMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? Dav Pregnant at time of death signed by the at d be detached fo 2 No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b, Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? certificate has 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital: Other: 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (SpecifyHOSPTCE After this 27. Man r of Death 28b. Time of 28c. Injury at work? 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending after death. Director: Aft within 24 hours after death.

To the Funeral Director: A completely filled in by the filled in the f 2 Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) R143201 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

DEBRAH MILLER,

DEC

31. Date filed (Month, Day,

CRNP

32.

6001

Registrar's Signatur

MUNCASTER MILL RD.,

ROCKVILLE,

MD 20855

mended 10c		12/15/11, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene							
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11egany Co	•	Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of D	2. Date of Dea	Reg. No.			
Physicia Medic		Thomas Vinc		ming ham	J. Date of Dea	ath 3. Time of Death 3. Time of Death M			
Examin	er	4a. Facility Name (if not institution, give street WMHS REGIONAL I	et and number) MEDICAL CENT	ER Cumb	Location of Death erland	4c. County of Death Allegany			
Funeral Director		Social Security Number     6. Sex	7. Age (In yrs. last b		If Under 24 Hrs. 8. Date of Birt Hours Min. (Month, Da	9. Birthplace (State or Foreign Country)			
3	Ļ	Usual Residence of Decedent  10a. State 10b. County	10c City To	wn or Location	1-21-	10d. Inside City Limits			
Marylar 28a-f sl	irecto	PA BEDFORD		Cuminghan	-OR- HYNE				
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 149 Cunningham	Dr	10f. Zip Code	5	10g. Citizen of What Country?  USA			
eath v	Fun		Was Decedent Ever in U.S.	13. Was Decedent of His	spanic Origin? (Specify Yes or No-	14. Race - American Indian,			
36 fter de fter de amine	by	1 Never Married 2 Married	Armed Forces?  1 X Yes 2 No If Yes, Give	If Yes, specify Cubar  1 ☐ Yes 2 🔀 No	, Mexican, Puerto Rican, etc.)	Black, White, etc.			
ooc	Completed		Year or Dates. 1953-60			Specify: White			
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21215-0036 within 72 hours after gjene. ler than "hatural", of the Medical Exami, the Medical Exami		Elementary/Seconday (0-12)	College (1-4 or 5+)	FOREMAN		RAILROAD			
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Baltimore, Maryland permit. Page 1 and 2 should be filed bepartment of Health and Mental Hymportant: If item 27 is marked oth any injury or other traumatic event once.		19a. Informant's Name/Relationship (Type, MARY ANN CUNNING)			nd Number or Rural Route Numbe	r, City or Town, State, Zip Code) LS CHURCH VA 22042			
re, 1 and f Heal frem (		20a. Method of Disposition	20b. Place	of Disposition (Name of	Date	20c. Location - City or Town, State			
MO Page nent o ant: If		1  Burial 2  Cremation 3  Per 4  Donation 5  Other (Specify)	noval from State ceme	etery, crematory or other place of the control of t	tery 12-16-11	Connellsville PA			
Balti permit. Departinimporta		21. Signature of Funeral Service Licensee	2 112	22. Name and Addres	s of Facility HARVEY H	ZEIGLER F.H. INC			
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be executed ician and burial-transit		that initiated events c resulting in death) Last	Due to (or as a consequence	e of):					
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687 sertifical	/Me	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pregnancy			23d. Date of delivery			
30x death c	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 2 ☐ Fetal de: 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 Lectopic pregnancy h 5 Other (specify)	у	Month Day Year			
od by the	, Phy	9 ☐ Unknown  Part II. Other significant conditions contril		ig in the underlying cause giv	en in Part I. 23e. Did t	obacco use contribute to the cause of death?			
ds, F juires then signer	ed by	CHRONIC K	IDNEY	DISEASE	1 🗆	Yes 2 10 3 Probably 4 Unknown			
Division of Vital Records, P.O. Box 6876( ral or Attending Physician: The law requires that the death certificate is after death.  In Director: After this certificate has been signed by the attending phyadin by the funeral director, page 2 should be detached for use as the	Completed by	CORONARY A	RTERY D	REASE	24a. Was auto				
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ng Ph fter thi		27. Manner of Death  Natural 5 Pending		o. Time of 28c. Injury injury work	at 28d. Describe	now injury occurred			
sion ttendi death stor: A r the fu	Certificate:	<ul> <li>✓2 ☐ Accident Investigation</li> <li>3 ☐ Suicide 6 ☐ Could not be</li> </ul>	28e. Place of Injury - At home,		Yes 2 No	Street and Number or Rural Route Number,			
Division A safter al Direct		4  Homicide determined	building, etc. (Specify)	rami, street, ractory, onice	City or Tov				
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the total states.	Medical	(Check 2 Medical Examiner:	On the basis of examination and	d/or investigation, in my opinio		and place, and due to the cause(s) and manner stated.			
<b>To the</b> within <b>To the</b> хотрlе	Σ	only one) 3 ☐ Certifying Nurse Po 29b. Signature and title of certifier	actioner: To the best of my kno	owledge, death occurred at the 29c. License	e time, date and place, and due to the number	29d. Date signed (Month, Day, Year)			
		> William 7	Tarm M	O Q	025406	DECEMBER 11, 2011			
10+		30. Name and address of person who comp		a) (Type, Print)	land MD 215	502			
)//KS Stat	e	William Lamm M 31. Date filed (Month, Day, Year)	32. Registrar's Signature	L. W.I	THE PLEASE				
Registra		DEC 15 2011	and it of	2 September 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Martha Diane Cenko 2011 Medical December 8:00 A. 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death Calvert 3125 Hickory Ridge Road Dunkirk Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 💢 F Days 182-42-0534 Months Hours 0673071950 Director 61 Pennsylvania Usual Residence of Decedent Show with the Maryland 10a. State 10b. County must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD 1 Yes 2 No Calvert Dunkirk ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3125 Hickery Ridge Road 20754 U.S.A. items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Medical Examiner 14. Race - American Indian, Armed Force 0 þ Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🏋 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🏋 No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation المالية المال 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the optometrist health care Be 17. Father's Name (First, Middle, Last) Should be file h and Mental F 7 is marked of 18. Mother's Name (First, Middle, Maiden Surname) ပ Modest traumatic Kuzmowych Theodora unobtainable 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh.
Department of Health an
Important: If item 27 is 1
any injury or ----19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3125 Hickory Ridge Road, Dunkirk, MD Alexis Cenko, husband 20754 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State cemetery, crematory or other place Allied Crematory 12/17/2011 4 Donation 5 Other (Specify) Bensalem, PA Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
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1 Yes 2 No 3 Ectopic pregnancy for 5 Other (specify) Pregnant at time of death Month signed by the a d be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate Yes 2 X No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 XNo မှ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work Accident Suicide Investigation 1 Yes 2 No Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Medical 29a. Certifier 1 Z Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 1 (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

dRW 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter L. Wisniewski, M.D., 110 Hospital Rd., Suite 310, Prince Frederick, MD 20678
31. Date filed (Month, Day, Year) 32. Registra's Signature

D40370

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 December 1:05 Рм Medical Thomas Anthony Cov1e 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9019 Chesapeake Calvert Avenue, North Beach 6. Sex 1 ☑ M 2 ☐ F Social Security Numbe Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. (Month, Day, Year) Wash D. Director 212-66-3499 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No North Beach MD Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9019 Chesapeake Avenue, # 17 20714 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Dock Master Charter Boat Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bernard James Coyle Frances Lohr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary B. Coyle, Sister St. Michaels Drive, Bowie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 12-13-11 Alexandria, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. William M00715 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) schender 1ext Medical Due to (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for ea a consciouence of: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 use as the 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No Pregnant at time of death Month signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 No 1 Yes 2 No certificate or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death 2 Accident
3 Suicide
4 Homicide Accident Suicide Investigation completed filled in by the I 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifi D16823 12-12-201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 KW Robert Schlager, 8924 Chesapeake Avenue, North Beach, MD 20714 M.D., 32. Registry's Signature 31. Date filed (Month, I State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42274 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 13, Kenneth Mickel Casey 2011 0144 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours 213-84-7851 Director 1 🛣 M 2 🗆 F Aug. 25, 1961 Germany Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland Harford Aberdeen 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 121 West Aztec Street 21001 U.S.A. or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🕅 No 1 ∐ Yes If Yes, Give 1 ☐ Yes 2 🕅 No Specify: Specify. White "natural", 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Harford Systems, Inc. 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Sec TweIve condary (0-12) Years College (1-4 or 5+) Aberdeen, Maryland Sheet Metal Worker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lieselotte Stamminger pe Donald Baldwin Casey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Kay Lynn Campbell Casey (wife) 121 West Aztec Street, Aberdeen, Maryland 21001 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State West Chester, 1 🔲 Burial 2 🗓 Cremation 3 🗆 Removal from State R.A. Ferris & Co., Inc. 12/14/11 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvánia re of Funeral Service Licensee Sign <sup>22</sup> Name and Address of Facility
Lee: A. Patterson & Son Funeral Home, P.A.

Perrvville, Marvland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Abnilation Immediate Cause (Final Onset and Death venticular Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner men momes Sequentially list conditions. if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events Due to (or as a consequence of) resulting in death) Last attending physician by Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₩ Unknown Records, Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Ves 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. M. n r of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be within 24 hours after deat To the Funeral Director: Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide determined S Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christa Fisher

31. Date filed (Month, Day, Year)

DEC 19 2011

August A. Januar (Check State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician/ Month Year 8:40 P M William Victor DeVore 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Frostburg Village Nursing & Rehab Frostburg If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number . Age (In vrs. last birthday) **Funeral** 1 MM 2 🗆 F Months Hours June 10, 1924 218-12-5734 87 Maryland Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1X Yes 2 ☐ No MD Allegany Frostburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21532 U. S. A. l Taylor Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian rmed Forces?
X Yes 2 No 1943 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes X☐ No Specify: Specify: Completed 3 XWidowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Textile Machine Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Olive (Plummer) DeVore မှ Victor DeVore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Pinecrest Dr., Frostburg, MD Roy V. DeVore 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/27/2011 Flintstone, MD Rocky Gap Vet. Cem 22. Name and Address of Facility Hafer Funeral Service, PA 21. Signature of Funeral Service Licenses 1302 National Hwy., LaVale, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Di sun Physician Onon Am disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Obstanting Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 No Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: Natural 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 721244 12/24/20. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harjit Sidhu, 925 Bishop Walsh Rd, Cumberland, MD 21502

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible links Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>10 Physician/ 2011 12:48AM Dodson December Nancy K. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Wicomico Nursing Home Salisbury Wicomico 7. Age (In yrs. last birthday)
72 Yrs. 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 0170371939 New Jersey 553-50-4872 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location Director 1 🔀 Yes 2 🗌 No Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21804 709 College Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married NUNCY Ded Son Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White "natural" Completed 3 Widowed 4 K Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) the Medical Transcriptionist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kathleen VanAuken Jorge Booth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 23381 Cove Rd., Chance, MD 21821 Ray Sperl/Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 Cremation 2 Removal from State Parsons Cemetery 12/14/2011 Salisbury, MD Donation 5 Other (Specify) re of Funeral Servi 22 Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se, or complications t hock, or heart failure. List only or Onset and Death Immediate Cause (Final Physician/ isease or condition resulting in death) Medical Due to (or as a consequence of Examiner Myeloma Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Year Day Pregnant at time of death be detached 1 ☐ Yes ∠ ⊆ g ☐ Unknown a Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 2 WNo Yes Physician: 25. Was case referred to medical 26. Place of Death ( eck only one) Be Hospital 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann P Death 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th 28b. Time of Certificate: 28c. Injury at 28d Describe how injury occurred iniury work?
1 Yes 2 No Natural 5 Pending Division Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined Medical 29a. Certifler 🛂 🎖 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the l within 2 To the F 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) 4TE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahesha Thimmarayappa MD 910 Easternshore Dr Salisbury MD 21804 egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42277 1 = State Registra Ameno#25.26. PerPhys. PGC12-21-11cr Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Anthony Paul Dugan, Jr. 3:10 Ам December 16, 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery 19716 Maycrest Way Germantown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) Days Hours Min 1 🖾 M 2 🗆 F Months Washington, DC 577-38-8375 82 Yrs Director 18, 1929 October | Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits with the Maryland notified at Director 1 X Yes 2 No Ocean View Delaware Sussex 10e. Street and Number 0 10f, Zip Code 10g, Citizen of What Country? Examiner must be 23a Funeral 19970 503 Lloyd Street USA items death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status rmed Forces?

X Yes 2 No ARMY Black White etc. 5 by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates. 1948–1952 1 ☐ Yes 2 No Specify: Specify: White "natural", Completed 3 Nidowed 4 Divorced the Medical 15. Decedent's Education Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Western Electric Phone Technician 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H 2 Evelyn Evangeline Carey Anthony Paul Dugan and 2 should be traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. 19716 Maycrest Way, Germantown, MD 20876 Catherine E. Goodman / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Brentwood, Maryland Fort Lincoln Cemetery 12/21/2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami the burial-transi attending physician and Due to (or as a consequence of) Physician/Medical as yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death be detached signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnous been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe page 2 certificate 2 1 Yes 25. Was case referred to medical Hospital or Attending Physician; funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: .2**XX**No 잍 1 \sum Yes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manny of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After injury Natural 5 Pending death. 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deatl Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Opertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signat 29d. Date signed (Month, Day, Year) 29c. License number ress of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Decembe F. Arnold Deichelman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Community Hospital Prince Georges Lanham 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 1 🔀 M 2 🗆 F Days Hours Min 03/26/1926 212-22-6786 Director 85 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director notified 28a-f Maryland | Prince Georges Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or ner must be r Funeral 6309 Barrs Lane 20706 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Ves 2 No WWIIIf Yes, Give
Year or Dates. Korea Black, White, etc. ō ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify. "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) al Hygiene. d other tha Elementary/Seconday (0-12) College (1-4 or 5+) United States Navy Fighter Pilot Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Anna Deichelman Arnold F. Deichelman, Sr. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Patricia Melton (Daughter) <u>Mashie Drive SE Vienna.</u> Va 22180 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Chesapeake Crematory 12/19/2011 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ren on Hale Funeral Home Signature Fineral Service Licensee 9013 Annapolis Rd. Lanham, MD 20706 23a. Par 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician/ disease or condition Medical resulting in death) as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death
Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 robably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy 24 N Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: nours after death.

neral Director, After this or
dilled in by the funeral dire 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 0102

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZAMA, MD.

31. Date filed (Month, Day, Ye

0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

42278

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Month

death?

Day

2 No

Year

1 Yes 2 X No

Maryland

White

201

9:00A M

State Registrar DHMH 17 Rev 7/2009

10

8118 Good Luck Rd.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 450M Kiyan Vando Duffy Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NICAMICO TENIASULA Medrac If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Age (In yrs. last birthday) Days Min (Month, Day, Year) **Director** 1 X M 2 🗆 F Maryland 12-03-2011 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 X Yes 2 □ No Maryland Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? USA 21801 909 Gateway Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Completed by 1 X Never Married 2 Married 2 X No Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NIA NA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Latoya White Kevin Duffy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. 909 Gateway Street, Salisbury, Maryland 21801 Latoya White mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 12 | 12 | 2011 | Salisbury, Maryland Parsons Cemetery Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Holloway Funeral Home P.A.
501 Snow Hill Rd., Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No been signed by the should be detached 9 🗌 Uпknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a, Was an cate has the page 2 s autopsy performed this certificate Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes ဂ္ 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) hours after death.

neral Director: After this y filled in by the funeral di Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and it certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michele 100E Urban 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Box 68760

P.O.

Records,

Division of Vital

4b. City, Town, or Location of Death

2. Date of Death

December 8,

Month

3. Time of Death

2011

4c. County of Death

4:37 A M

Physician

/Medical

**Examiner** 

1. Decedent's Name (First, Middle, Last)

Russell B. Dickerson

4a. Facility Name (If not institution, give street and number)

signed by the a d be detached for Division of Vital Records, cate has I page 2 s certificate ne Hospina. ...
in 24 hours after death.
the Funeral Director: After this certificate
the Funeral Director, or an only the funeral director, pe Hospital or Attending completely filled in by within 2.

Worcester Snow Hill 5449 Shell Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□F Maryland 84 Director 221-18-2100 Feb. 5, 1927 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🔀 No Director Snow Hill MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5449 Shell Road 21863 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ▼ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 ☐ Never Married 2K Married Baltimore, Maryland 21215-0036 1 □Yes 2XXNo If Yes, Give Year or Dates Specify: Specify: white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lulu Moore Virgil O. Dickerson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 a Department of Health a Important: If item 27 is any injury or other trau once. 5449 Shell Road Snow Hill, MD Julia C. Dickerson (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Dec. 12, 2011 Snow Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bates Memorial Cem. 22. Name and Address of Facility
Short Funeral Home 21. Signature of Funeral Service Licenses Delmar, DE 13 East Grove Street Approximate Interval Between Onset and Death detations that thused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on e ch line. 23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Physician arkenson /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2. No 1 ☐Yes 2 ☐No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1604-Market 00 31. Date filed (Month Year) egistrar's Signature Registra DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Physician/ Day O Year Dumas 905m Mary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Health, Nursing & Rehab Ctr Cumberland Allegany If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Days 09/20/1968 West Virginia 103 236-01-9192 Director Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Director MD 1X Yes 2 □ No **Allegany** Cumber1and 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 214 Saratoqa Street 21502 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygjene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) Unknown College (1-4 or 5+) Homemaker **Home** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alexander Gillis Rose Beckner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Dumas / Son 13811 Bluejay Drive, S.W., Cumberland, MD 21502 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🎛 Cremation 3 ☐ Removal from State cemetery, crematory or other place) Cumberland Crematory 11/2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Upchurch Funeral Home, P.A. 202 Greene Street, Cumberland, MD 21502 21. Signature of Funeral Service Litena 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ronau disease or condition Medical resulting in death) Due to (or as a cons buence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 Probably 4 ☐ Unknown cate has been significated to page 2 should to Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2-1 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director; After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 1 Yes 2 No М Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗌 🌣 rfifting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. of certifie 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 2011 Dec 10 0033280 8 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland. Aue

State Registrar Registrar's Signature

11-09306 Robert Dale Elliott Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2011 42282

		1- For State Registrar	,	Cer	tificate of	Death			Re	g. No.	<u> </u>	7620
Physicia edical Exami	an/	1. Decedent's Name (First, Middle,La Robert Dale	e Elliott			_			2. Date of Death Month December	Day Year 10, 2011		3. Time of Death 1441 hrs
		la. Facility Name (if not institution, give street and number)  Calvert Memorial Hospital  4b. City, Town, or Location of Death Prince Frederick						4c. County of De Calvert				
Funeral Director		5. Social Security Number 6. \$ 212-62-2475	Sex 7. Age	(In yrs. la	ast birthday) Yrs.		ear If Und		8. Date of Birt 12/25/	h(мм/DD/YYYY) 1954	Foreign	nplace (State or ytdvand
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 23a-f abow any numatic event, the Medical Examiner must be notified at once.	tor	Usual Residence of Decedent  10a, State  10b, County  Maryland  Calver  10e, Street and Number	t		Town or Locati mes Is1				110	og. Citizen of Wha	at Count	10d. Inside City Limits 1 Yes 2 No
	Director	3971 Oyster Hou	r House Road 20615 United St					Stat	es			
	by Funeral	11. Marital Status 1	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S	If Y	es, specify Cul	oan, Mexicai No <i>specify</i>	n, Puerto F y:		14. Race - White, Specify: W	etc.	an Indian, Black,
	Completed b	15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade com College (1-4 or 5		during m	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  echanic Auto				iness/In	dustry	
	Be Con	17. Father's Name (First, Middle, Las Edward Luther E		I					First, Middle, M arie Pa	Maiden Surname) arks		
	٩	19a. Informant's Name/Relationship (R. Dale Elliott,	•		19b. Mailing Address (Street and Number or Rural Route Number, City or Town 5405 Long Beach Road St. Leonard, MD					nard, MD	206	85
Baltimore, MD 21 permit. Pages I and 2 should I Department of Health and Meel Important: If them 27 is max injury or other traumatic eve		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other Specif	_	te C	rematory or oth	sition (Name of cemetery, her place) 12/12/2011 20c. Location - C tan Funeral Service Alexandr						<sup>Town, State</sup> Virginia
Baltir permit. 1 Departm Imports injury of		21. Signature of Funeral Service Lice Barbara Rausch M	nsee 100440 pe	r DVI	R 440	05 Broo	mes I	s. Rd	. Port	ral Home Republic	c MI	20676
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart								Approximate Interval Between Onset and Death		
Examiner		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.										
	Examiner	if any, leading to immediate  cause. Enter Underlying Cause (Disease or injury that initiated  events resulting in death). Last  Due to (or as a consequence of):  Due to (or as a consequence of):										
cecuted and rand			d	querice or	· J·							
cords, P.O. Box 68760, law requires that the death certificate be executed has been signed by the attending physician and 2 should be detached for use as the burial - transit	ian/Medical	UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom  1 Live birth  4 Pregnant at 1		2 Fe	tal death	3 Ectop	oic pregnan	ncy	23d. Date of o		ay Year
Box 687 he death certification by the attending property the death of the attending property the death of the	Physicia	1 Yes 2 No 9 Unknow	yn 9 Unknown		J Off	her (Specify)	e civen in F	Part I	23e Did to	bacco use contrib	oute to t	he cause of death?
S, P.O. iires that the signed by d be detach	ð	Fait II. Outer significant conditions	contributing to death		ssurang in the b	inderlying caus	- GIVEITIII	art i.	1 Yes	2 <b>✓</b> No 3	Prob	ably 4 Unknown
The Tage	Completed								24a, Was a autop: perfor	sy pr m <u>ed</u> ? de		opsy findings available ompletion of cause of
ital Reician: The scertificate rector, page	Be	25. Was case referred to medical examiner?	Hospital:	at 2 🚅	ER/Outpatient		Other4			Residence 6	Other:	
Sion of Vital   Attending Physician: r death. ector: After this certifi by the funeral director,	tion: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending	28a. Date of Injul (Month, Day, Ye Dec 10, 2011	y I	28b. Time of I	njury 28c. I	njury at Wor	rk?	,	now injury occurre		
를 출출 를 드	Certification	3 Suicide 6 Could no	determined (Specify) Single Family Home									
To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  One)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
7 × 7 8	Me	and manner stated.  29b. Signature and title of certifier  O.C.M.E.  29d. Date signed (No. December 11, 2)										
w 5		30. Name and address of person who completed cause of death (Item 23a)  Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223										
	tate		32. R gistrar								-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 19 2011 05:30 PM FRANK MERLIN ENGLAND Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CECIL 1141 WEST OLD PHILADELPHIA ROAD NORTH EAST If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth APRIL Day Year) 937 1**X**XM 2 □ F Days WEST VIRGINIA 236-54-6803 Director 74 Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Medical Examiner must be notified at Director 1 Yes 2X No MARYLAND CECIL NORTH EAST 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 1141 WEST OLD PHILADELPHIA ROAD UNITED STATES 21901 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò þ 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 XNo Specify: Specify. "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working AUTOMOTIVE and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the MANUFACTURING MAINTENANCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ GRANT ENGLAND BESSIE BAILEY traumatic 19a. Informant's Name/Relationship (Type, Print) and Number or Rural Route Number, City or Town, State, Zip Code, PHTLADELPHIA ROAD, P.O. BOX 72 Department of Health an Important: If item 27 is any injury or other trau KATHERINE P. ENGLAND SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State DECEMBER 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 23, 2011 NORTH EAST, MARYLAND 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND21901 23a. Part 1. Enter the disease, or complication 1 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician | disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy Yes Yes Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: ner of Deat 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury Netural 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) ature and title of certifier 29d. Date signed (Month, Day, Year) s of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 42284 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Fanelli John Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland WMHS-RMC Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Birtnpio Country)PA 1 **X**M 2 □ F Sep 14 Months Yrs Director 185-30-3771 74 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at with the Maryland Director Cumberland MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 14206 Canal Road SE permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked others any injury or others. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2 ☐No Specify: Specify: Completed 3 Widowed 4 Divorced white Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Pharmaceutical Rep. Merck Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary N. Walker John P. Fanelli, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21502 19a. Informant's Name/Relationship (Type, Print) 14206 Canal Road SE wife Mary Fanelli 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Xeremation 3 ☐ Removal from State 12/20/20 MD Cresaptown Donation 5 Other (Specify) of Funeral Servi Licensee 22. Name and Address of Facility and Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner B 0 Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Physician/Medical Examiner attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicis mpleted filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2-1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Yes 2 - No မ 1- Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 A Natural work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cerifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) Dec 20, 2011 DOC 33280 en 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kent: Ave. Ste. 101 Cumberland, MD 21502 025

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death ME'C. Physician/ 24 2 0°11 12:25A M FOWLER ETHEL MAY Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min SEP. 11, 1925 Hours MARYLAND 212-20-1858 Director 1 🗆 M 2 🔀 F 86 Yrs Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f sho must be notified at Director 1 ☐ Yes 2X No MD CHARLES WALDORF 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 4140 OLD WASHINGTON ROAD 20602 U. S. A. items death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ö þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: WHITE "natural", 3 XWidowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) AT HOME HOMEMAKER Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be 1. Department of Health and Mental Important: If item 27 is mediany injury or other? and Mental is marked 2 BEATRICE SOUDER CHARLES SOUDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5910 GARY DRIVE WELCOME, MD 20693 BETTY ZDRADZINSKI/DAUGHTER 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition DECEMBER 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State FT.LINCOLN CEM. BRENTWOOD, MD 30, 2011 4 Donation 5 Other (Specify) SERVICE, P.A. Signature of Funeral Service Lic 22. Name and Address of Facility RAYMOND FUNL. 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No To the Hospital or Attending Physician: The law requires that the death Month Pregnant at time of death 5 Other (specify) signed by the at the detached for g Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy has perform death? 1 ☐ Yes 2 ☐ No After this certificate Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Box 100 A DOA Certificate: To 28a. Date of injury (Month, Day, Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at 28d Describe how injury occurred 5 Pending 1 X Natural work? 1 ☐ Yes 2 ☐ No s after death Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title of certifier completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Date filed (Month, Day,

4

32. Registrar's Signatur

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** December 13, 2011 1:20 Carl Bernard Friedrich /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner South River Nursing Home & Rehab. Edgewater Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F 90 1921 Cottage City, MD Director 14, 577-24-2359 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 1 ☐ Yes 2 X No Director MD Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be 144 Washington Road 21037 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 □ No WWII If Yes, Give Year or Dates: Coast Guard 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. Completed by 3 Nidowed 4 Divorced White ss 1 and 2 should be filed within 72 hou of Health and Mental Hygiene. item 27 is marked other than "natural rother traumatic event, the Medical E. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Linesman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Margaret Elizabeth Smith Oscar Herman Friedrich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 6000 Forest Road, Cheverly, MD 20785 Mark C. Friedrich / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 12/28/2011 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Cons Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any reading to furnished cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed2 certificate 2 No Division or Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 Tes 1 🔲 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation To the Hospitar committee within 24 hours after death.

To the Funeral Director: After the Funeral Piled in by the funeral piled in by the funeral piled in by the funeral piled in by the funeral piled in by the funeral piled in by the funeral piled in by the funeral piled in by the funeral piled in by the funeral piled in by the funeral piled in piled in by the funeral piled in 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tiple of certifier MI) Coun 00053709 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 14300 Gallar

CHAVLA

31. Date filed (Month, Day, Year)
DEC 2 1 2011

Ion STE # 210 BWIL MI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:52 AM 3-2011 13 Margurite /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Camden Wicomico South truitland Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months 221-10-9818 Director 11-20-1922 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be norther at 10d. Inside City Limits 10c. City, Town or Location 1 ✓ Yes 2 ☐ No Director Fruitland  $m \, n$ Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U-S-A 21821 Funeral amden 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Whitz þ 3 ₩Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) defuge HouseKeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 -mma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8100 Atlanti Bailey Wallops Island, VA 23337 Linda 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State -7-2011 Oak Hall, UA 4 ☐ Donation 5 ☐ Other (Specify) Cemelery Chinceleague, UA 23336 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home, Inc. 6327 Church St Botto Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COPD Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes '2 ☑ No 24a. Was an performed No No Division or Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes V No 2 27. Mariner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Funeral Director; After t completely filled in by the funera Certification: To the Hospital or Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)63199 12/5/11 3701 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) SALISBURY 910 EASTERN SHORE VO HAA DEESIL 31. Date filed (Month Day egistrar's Signatyr Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rankie Eugene	Fav	1- For State Certificate of		yglerie Reg.	201	1 4228				
Physici		1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death 2247 hrs				
Medical Exami	ner	Trankie Bagene Tavorice	4b. City, Town, or Location of Death	Month D December 2	2, 2011 4c. County of Death	2247 1115				
. /		Frederick Memorial Hospital	Frederick		Frederick					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 215-82-8759 1 M 2 F 50 Yrs.	If Under 1 Year   If Under 24Hrs   Months   Days   Hours   Min	_	MM/DD/YYYY) 9. Birth 4,1961 Foreign Cou	place (State or ntry,Maryland				
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locati	ion			10d. Inside City Limits				
B .,	ŗ	MD Frederick Thurmont				1 Yes 2 No				
Maryland 28a-f show	Director	10e. Street and Number	10f. Zip Code		Citizen of What Coun	try?				
with the Maryland ms 23a or 28a-f she be ootified at ooce	I	12621 Layman Road	21788		U.S.A.	oon Indian Plack				
eath with t items 23a	Funera	1 Never Married 2 Married Armed Forces? If Yo	is Decedent of Hispanic Origin? ( S es, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	an maan, black,				
after de	by Fu	or Dates:	Yes 2 No specify:		Specify: Whi					
hours a		15. Decedent's Education (Specify only highest grade completed)  16a. Deceden during modern management of the complete of the	it's Usual Occupation (Give kind of ost of working life. DO NOT use ret		6b. Kind of Business/Ir	ndustry				
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)		e (First, Middle, Ma						
121 Id be fi Aental J	o Be	Francis Eugene Favorite  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing	g Address (Street and Number or	ginia Ru Rural Route Numbe		Zip Code)				
MD 2 nd 2 shou alth and M m 27 is m	٩		nny Court, Thur							
		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State  20b. Place of Dispos crematory or oth	sition (Name of cemetery, her place)	Date	20c. Location - City or	Town, State				
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify Smithsbur	g Crematory 12-	-28-11	Smithshurg	. MD				
Balt permit. Depart Impor			Period Address of Facility			, P.A. 21788				
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	5 East Main Stre he mode of dying, such as cardiac	or respiratory arres		Approximate Interval Between Onset and				
/Medical Examiner	á S	Immediate Cause (Final disease a.Hemopericardium								
ZAGIIIIICI		or condition resulting in death)  Due to (or as a consequence of):  bAortic Dissection								
	ē	Sequentially list conditions,								
, ii	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit		d.  IN UNPENDED ☐ AMENDED 23a-b, pt.II, 27, per me, g923 1-13-12 sm								
'60, ate be chysicia	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery					
Box 6876  death certificate the attending phy ed for use as the l	ian/	past 12 months?	etal death 3Ectopic pregn ther (Specify)	ancy	Month D	ay Year				
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rds, le requires been sig	Completed by	Atheroscierotic Cardiovascular Disea	156	24a. Was an		topsy findings available				
e law re	ag m			autopsy perform 1 ✔ Yes 2	ed? death?	ompletion of cause of				
tal Reco		25. Was case referred to medical	26.Place of Death (Check							
F: E: E: E: E:	To Be	examiner? 1 Ves 2 No  Hospital: 1 Inpatient 2 FR/Outpatient			esidence 6 Other					
⊏ ਵੀ ੂੈ ਵੀ	Ë	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of I	Injury 28c. Injury at Work?	28d. Describe no	w injury occurred					
Division tal or Atteodi rs after death.	ficati	2 Accident Investigation 28e. Place of Injury - At home, farm, stree	et, factory, office building, etc.			ral Route Number, City				
Divisi pital or Ati ours after d eral Direct filled in by	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, Sta						
Division  To the Hospital or Atteowithin 24 hours after death To the Fuoeral Director:		(s) and manner as state nd place, and due to th	ed. e cause(s)							
To To Toom	Medical	and manner stated.  29b. Signature and title of certifier	29c, License number		nth, Day, Year)					
		anetz	O.C.M.E. December 23, 2011							
		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 900 W. Balt	timore Street Rollimore M	ID 21223						
2	tate	31. Date filed (Month. Day Year) 32. Registrar's Signature		.D & 1&&U						
Regis		BEO 0 0 0011	arkel	<u> </u>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #7 per DVR G923 1/6/12 dk
State of Maryland / Department of Health and Mental Hygiene 42289 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Garris  $P^{M}$ Vivian Inez <u>December</u> 2011 5:54 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Berlin Nursing Rehabilitation Center Worcester Berlin If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) Bir., 29 29 **Funeral** 1 M 2 T Days Hours Min Months Maryland 90 Director 216-12-1049 March 192 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at 10a, State Director 1 Tes 2 No Maryland Worcester Berlin 9 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral or items 23a 10814 Oak Court 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black. White, etc. 3 1 Never Married 2 Married within 72 hours after Garris, Vivian Baltimore, Maryland'21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: "natural", Specify: Completed 3 X Widowed 4 Divorced Black event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Worcester County Board al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Of Education aborer/cafeteria worker Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John E. Franklin Eleanor Robins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104319a. Informant's Name/Relationship (Type, Print) Iris F. Mapp/niece 3570 Courthouse Drive. Apt. 1C Ellicott City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Paul UMC Cemetery 12/9/2011 Berlin, Maryland 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD Sigrature of Funeral Service Licensee, Jolley Memorial Chapel 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Interval Between Immediate Cause (Final Onset and Death Physician 101 disease or condition 121mg Medical resulting in death) Due to (or as a consequence of) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events 00 attending physician and for use as the burial-tran Due to or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 🔀 No bed by the atter Day Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No ☐ Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 🗌 Yes Other: ပ 2 XNo 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, December 5, 2011 TE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William 9715 Healthway Dr, Berlin, 21811 Η. Robins, MD MD 31. Date filed (Mont), 13, We 32. gistrar's Signatu State Registrar

			_ FOr	partment of Health and N ertificate of Death		2011 12201				
			Registrar  1. Decedent's Name (First, Middle, Last)	erillicate of Death	2. Date of Death	3. Time of Death				
	Physicia		E. PEARL GAUTHIER		Month DEC. 15	Day Year 1:45 P M				
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death				
	LXdiiiii	CI	HOMEWOOD AT WILLIAMSPORT	WILLIAMSPORT		WASHINGTON				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months   Davs   Hours   Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)				
	Director		578-32-1753 1 M 2 F 89 Yrs	Monard Days	9/21/19					
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits				
	Maryl -f she	tor	MD WASHINGTON WI	LLIAMSPORT		1 ☐ Yes 2 ☐ No				
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g	g. Citizen of What Country?				
	th with	alD	16505 VIRGINIA AV.	21795		USA				
	ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto</li> </ol>	pecify Yes or No- c Rican, etc.)	14. Race - American Indian, Black, White, etc.				
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, it. M. deal Evenither Last to prefifted at	by F	1 Never Married 2 Married 1 Yes 2 No	1 □Yes 2√□No Specify:		Specify: WHITE				
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<u>ya</u>		2	WALKER C. BRANNON		HEL V. De					
Baltimore, Maryland 21215-0036	ha ris		1,77	ailing Address <i>(Street and Number or Ru</i> 6 CUSHWA ROAD <b>,</b> MAR						
o,	1 and Heal em 2 ther		20a Method of Disposition 20b. Place of Di			Oc. Location - City or Town, State				
פֿב	Pages nent of int: If its iry or o		cemetery, c		Date . 18,	MARTINSBURG, WV				
	permit. Pages Department of Important: If it any Injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility		RAL HOME, PO BOX 821,				
ă	Dep any		Robert Chields	327 W. KING ST., M	ARTINSBURG,	WV 25402				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause of each line.							
-	Physician		Immediate Cause (Final disease or condition	7		Inserand Death				
₹ ~′	/Medical Examiner		resulting in death)  Due to (or as a consequence of):							
	LAdillilei	-	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):							
	ited nsit	Examiner	cause. Enter Underlying Cause (Disease or injury							
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Ř	leath certific attending p	an/I	23b. Was decedent pregnant  1  Live birth 2 Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery  Month Day Year				
5	The law requires that the death certificate ate has been signed by the attending phys. age 2 should be detached for use as the	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		,				
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ot <	hysic his ce I direc	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpa	tient 3 DOA Other: 4 Nursing F	lome 5 ☐ Residen	nce 6 Other (Specify)				
0	ding Physician: The In. After this certificate hit funeral director, page	on:	27. Manner of Death 1. Matural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) Inju	y Work?	28d. Describe how	v injury occurred				
<u>s</u>	ttend death stor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28f Location (Stre	eet and Number or Rural Route Number,				
DIVISION	after after Direction by	Certification: To	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	Street, lactory, office	City or Town,	State)				
	spita hours neral y filler		29a. Certifier 1 Certifying Physician: To the best of my knowledge, d							
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director. After this certifical completely filled in by the funeral director, t	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/cone and manner stated.	r investigation, in my opinion, death occi						
	Vith To 1	Ž	29b. Signature of certifier	29c. License number	290	d. Date signed (Month, Day, Year)				
	[ W		MEDICAL MEDICAL	m 11/06		14/16/2011				
	J 01		30 Name and address of pelson who completed cause of death (item 23a) (Ty	De Ave (TE 101	HAGGACTO	C4C/5/11/1000				
	Sta	te	31. Date filed (Month, Day, Year)  32. Register's Signature  33. Aparts	1	11100110					
	Registr	ar	JAN 0 4 2012 Denera B. gares							

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State of Maryland / Department of Health and Mental Hygiene

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	Physicia Medic			SHIRLEY	MARIE	GIBBONS		Month Decemb	per 23 20	11 3:18 AM_
	Examin	er	4a. Facility Name (if not institution, give		,	4b. City, Town, or			4c. County of D	
	Funeral		Frederick Memori 5. Social Security Number 6. Se	x 7. Age (I	n yrs. last birthday)	Freder	1 C K If Under 24 Hrs.	8. Date of Birt	Frede	Birthplace (State or Foreign
	Director		215-34-2842		73 yrs.	Months Days	Hours Min.	March	20°,1938 Ma	fry Pand
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	the M or 28 e noti	Ē	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "matural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral	5804 Bartonsville	Road		21704			United St	ates
	r item iner n		<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 X Married</li></ul>	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 XNo	r in U.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, /hite, etc.
920	s after ral", o Exam	d by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	1	☐ Yes 2 XNo	Specify:		Specify: Wh	nite
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≥ ໜົ	and 2 Health em 27 ther tr		Harold Gibbons Sr.	• •			lle Rd.,		ick, Maryl	
Baltimore, Maryland 21215-0036	Page 1 anent of hand of hand: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of Dispos cemetery, crem Mt. Olive	natory or other place	9) 12/2	Date 27/2011	20c. Location - City	, Maryland
븚	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tonce.	1	21. Signature of Funeral Service License							
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	ending use a	an/N	23b. Was decedent pregnant	23c. If yes, outcome of p	pregnancy Fetal death 3	Ectopic pregnancy	u.		23d. Date of	delivery
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	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director After this completed filled in by the funeral di	Medical	(Check 2 Medical Examin	ician: To the best of my ner: On the basis of exan e Practioner: To the bes	nipation and/or investi	gation, in my opinio	n, death occurred a	at the time, date a	ind place, and due to t	the cause(s) and manner stated.
	To th withir To th comp	2	29b. Signature and titl of codifier	2011	7	29c License	number		29d. Date signed Mo	
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	100		30. Name and address of person who c	0 /			Cool-	1 1 0	A 21===	1
	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's	300 W Signature	TUNT	rredev	ack, M	ND 2170	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 's Name (First, Middle, Last) 2 Date of Death Physician/ Medical (if not institution, give street and number) **Examiner** 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) If Under If Under 1 Year 24 Hrs. Funeral Davs Hours M 2 | F Months **Director** Usual Residence of Decedent or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location Director Yes 2 No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🖼 40 Specify. Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NQT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) PIVate 20 Demisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 19a. Informant's Name/Relationship (Type, Print) Drive Capital Heightshup Betty Gatewood Maryland GRK. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State monu 4 Donation 5 Other (Specify) Signa 22. Name and Address of Facility WISEMON Alexandrus Ferry Rd Clinton Mo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ CHRONIC NENAL FAILERS Medical Due to (or as a consequence of): Examiner We pro Renal Sindma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examin requires that the death certificate be executed CIRRWXSIS Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical MEDATITIS Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Month Year Pregnant at time of death 2 🗆 No been signed by the should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Records, 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has al director, page 2 autopsy Yes Division of Vital 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 2 No 5 Residence 6 Other (Specify) ٥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral o 27. Mapper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) To the 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) an weed 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19thSr.W. W #200 WhsdugtonDi LIMSON MO 20 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 3, ROBERT **GOWAR** 2011 М 1843 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death ALANTIC GENERAL HOSPITAL WORCESTER BERLIN Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours JULY 16. Country) NEW JERSEY **Director** 73 135-30-6372 Usual Residence of Decedent income many lightere.
I is marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 25a or 28a-f show rainmatic event, the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No SUSSEX FRANKFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 35557 PARKER ROAD 19945 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 

Yes 2 □ No Black, White, etc. 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BOAT CAPTAIN CHARTER FISHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MICHAEL A. GOWAR ANNA H. BREIDT t. Page 1 and 2 should by treent of Health and Mercant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NELLIE A. GOWAR 35557 PARKER ROAD, FRANKFORD, DE 19945 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o 1 🗆 Burial 2 ី Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY OF DELMARVA 12/5/11 DELMAR, DE 21. Signature 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASCVD disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant 9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death 2 🗌 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X N After this certificate 2 No 1 🗌 Yes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation within 24 hours after deat To the Funeral Director. 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of 30. Name and address of person who con IVX of death (Item 23a) (Type, Print) 100 E Carroll St.

Registrar

DHMH 17 Rev 7/2009

State

06 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William Leonard Green Medical 4a. Eacility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sa DICOMIC If Unde If Under 24 Hrs. Date of bill. (Month, Day, 7. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country)
Massachusetts Days 1 🛛 M 2 🗆 F Min. Director 222-12-1131 Yrs Sept 86 Usual Residence of Decedent 28a-f shov 10a. State with the Maryland 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD Wicomico Delmar 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 9110 Old Dagsboro Road 21875 U.S.A. and Mental Hygiene. is marked other than "natural", or items filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: WWII white Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Department of Health and Ment Important: If item 27 is marke any injury or other traumatic Sylvester Green Mary Grace Rennes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Green (Son) 5822 Edgehill Drive Alexandria, Va 22303 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Melson's Cemetery 12-17-2011 Delmar, Maryland 22. Name and Address of Facility Short Funeral Home 13 East Grove Street 21. Signature of Funeral Service Licensee Delmar, Part 1. Enter the disease, or complice shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease Of injury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ Unknown 9 Unknown Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed certificate Yes 2 1 🗌 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: မ 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne f Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 🗌 Yes 2  $\square$  No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) SAT 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 108 910 SHOREDR, SALISBURY MD 21804 16 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 18<sup>Day</sup> Physician/ 11:00 A M 2011 Nancy D. Groom Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Sun <u>138 Wilson Road</u> Rising If Under 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) Hours Min. (Month, Da Country) 1 🗆 M 2 🗓 F 216-52-5620 Director 6/16/1947 64 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 X Yes 2 No MD Cecil Rising Sun 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21911 USA 138 Wilson Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Was Decedent Ever in U.S. Armed Force Black, White, etc. ð 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Perry Point VA Personnel Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Harriett Rogers Robert Britton Durgin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 138 Wilson Road, Rising Sun, MD 21911 Edward Groom - husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Prospect Hill Cemetery 12/23/2011 Towson, MD 4 Donation 5 Other (Specify) 21. Signatur ur ral Service Licens 22. Name and Address of Facility R.T. Foard Funeral HOme, PA S. Queen Street, Rising Sun, MD 21911 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final CANCER LUNG Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 D g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown After this certificate has been funeral director, page 2 shoult 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🗷 Residence 6 Nother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျှ 1 Tes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 X Natural 5 Pending the Funeral Director; After Institute for the funeral filled in by the 2 🗌 No Accident Investigation Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062190 2011

Registrar

0

State

2533 AUGUSTINE HERMAN HWY, SUITEA, CHESAPEAKECITY, MD 2195

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

KHAN

5 HA HNAWA Z 31. Date filed (Month, Day Year DEC 2 0 2011

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Phone and Pirector: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760,

1 Yes 2 X No CLINTON, MARYLAND Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed?

✓ Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA **T**0 Other Nursing Home 5 Residence 6 🗹 Other: Scene 1 🗸 Yes 28a. Date of Injury 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: 1 Natural Dec 17, 2011 Driver SUV that rolled over 0437 hrs 5 Pending 1 Yes 2 ✔ No 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) N/B I495 outer loop E/B Rt 44, Temple Hills, MD determined Homicide (Specify) Major Road / Highway 29a. Certifier 1 [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated: 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 17, 2011 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 32. Registrar's Signatu Registrar

Within 2

Please Type or Print in Black indelible in k2 Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death , Decedent's Name (First, Middle, Last) Physician/ Wayne Keith Henry . Medical 4a. Farility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner NICOM 100 MEDICAL 3AL136414 REGIONAL ININSULA If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 222-48-2013
Usual Residence of Deceden **Director** 1 🛣 M 2 🗆 F 49 3-27-1962 DE 28a-f show 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director 1 Yes 2 XNo MD Wicomico Parsonsburg 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 32495 Old Ocean City Rd. 21849 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give er than "natural", the Medical Exa Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4 or 5+) Drywall Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o 0 Harold Henry Shirley Timmons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tranonce. 32495 Old Ocean City Rd., Parsonsburg, MD, 21849 Lori Ann Henry wife Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 12 12 2011 Salisbury MD Salisbury Crematory : 21. Signature of Funeral Service Liver 22. Name and Address of Facility Holloway Funeral Home P.A. Snow Hill Rd, Salisbury, MD, 21804 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest so on each line. Part 1. Enter the disease, or complication shock, or heart failure. List only one could Approximate Interval Between Onset and Death Ph\_sician/ disease or condition Medical resulting in death) Examiner Secus flany let conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the use as IF FEMALE: ابر میرانین از این از کردین از Division of Vital Records, P.O. Box 6 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy page 2 1 Yes 2 No this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 Tes 2 No ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certificate: iniury 5 Pending 1 Natural Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier OTE ted cause of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20<sup>Day</sup> Physician/ Dec. 2011 1:25 AM Martin L. Hendrix Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center for Hospice Care Baltimore Towson 8. Date of Birth
(Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 183-18-7935 Director 1 🛛 M 2 🗆 F 88 ep. 1923 Maryland Usual Residence of Decedent f show or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Baltimore White Hall MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 ems 23a or must be r Funeral 19006 Graystone Road 21161 U.S.A. items death ו "natural", or item ledical Examiner ת Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Trucking Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Effie I. Miller Thomas Earl Hendrix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19006 Graystone Rd., White Hall, MD 21161 Lillian Hendrix, Wife or other 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. Date 23, Department of Important: If it any injury or o West Liberty United White Hall, MD 2011 4 ☐ Donation 5 ☐ Other (Specify) Methodist Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc 24 N. Second St., New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic 06 structure disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, loading to in modificactuse. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or sels conesquence by as the burial-transi and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Month Dav Pregnant at time of death 1 Yes 2 No 9 Unknown signed by the a 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy certificate has performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes ည 4 Nursing Home 5 Residence (Specify) WOSPLL 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. e and title of certifier License number 5830 29b. Signatu 29d. Date signed (Month, Day, Year) 20 2011 December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST MO 6701 W. CHANCES 31. Date filed (Month, Day Year Registrar's Signature

DHMH 17 Rev 06-2011

State

Registrar

Parket

32

42299 State of Maryland / Department of Health and Mental Hygiene 20 1 1 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2<sup>2</sup>4 2011 **Physician** Dec. 10:25 A. M Joseph Hayden /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Golden Living Center Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, NOV • 25 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Penna. 1 M 2 □ F 184-18-1182 92 Yrs. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r then "naturel", or iteme 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 □ No MD. Washington Hagerstown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 750 Dual Hwy. 21740 U.S.A. e filed within 72 hours after deeth is al Hygiene. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ð 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Crane Mfg. Superintendent Plant Engineering 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill trient of Heelth and Mental Hent: if Item 27 is marked oth jury or other traumatic even Florence Heater Joseph A. Hayden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry Tabler/POA P.O. Box 112 Greencastle, PA 17225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Importent: if eny injury or once. Church Hill Cemetery 12/30/2011 McClellandtown, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Zimmerman And Son Funeral Home Inc. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 45 S. Carlisle St. Greencastle, PA 17225 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician iandio resp DISTASE /Medical Due to (or as a consequence of): Examiner ARTERY DISEASE ORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine requires that the death certificate be executed physicien and s the burial-transit DIARGIES MELLI resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 HYPERTENSON Physician/Medical use as sate has been signed by the attending page 2 should be detached for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by NEOMONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ER 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2∕ No or Attending Physician: After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pendina 1.FTNatural s efter death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funare! D completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, 29c. License number Now MI DC07243 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BIDD'BUT MD 324 6 ANTIETAM N002 32. Registrar's Signature 31. Date filed (Month, State

DHMH 17 Rev 1/2001

Registrar

State Registrar 31. Date filed (Month, Day, Year)

Cumberland MD 21502

925 Bishop Welsh Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #196&20b&c Per FH G923 I/04/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 12:15 AM 2011 Dec <u>Richard Melvin Hite</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland, MD Devlin Manor Nursing Home 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthdav) 8. Date of Birth **Funeral** Hours Apr. 5, 1960 Maryland 51 Yrs **Director** 214-78-2180 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1X Yes 2 No MD Allegany Cumberland ritems 23a or 27 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21502 U. S. A. 435 Grand Avenue Examiner must 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black White, etc. 1 Never Married 2 K Married "natural", or þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify. White Specify. 3 Divorced 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working alth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Laborer Be permit. Page 1 and 2 should be file.
Department of Health and Mental Hw.
Important: If item 27 is marking any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Marian Billie Breedlove Hite Irby Rutherford Hite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street an**் Mercha**r or Rural Route Number, City or Town, State, Zip Code) 16116 Orchard News Dr., Cumberland, MD Marian B. Hite Mother 20a. Method of Disposition 20b. Place of Disposition (Name of Scanpe) Lenated Fremation y 20c. Location - City or Town, State Cresaptown, MD 12/27/2011 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cumberland, MD Pleasant Cemetery - Unknown -22. Name and Address of Facility Hafer Funeral Service, PA 1302 National Hwy., LaVale, MD 21502 21. Signature of Funeral Service Licensee tokn 1302 National Hwy., LaVale, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ alestolia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last physician and Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be exer Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? signed by the atte Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4- Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tyes ည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident work? 1 ☐ Yes 2 ☐ No Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) Dec. 27. 2011 DU017565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LaVale, AD 1,501 J7351/ine 31. Date filed (Month, Day, Year)

JAN 0 4 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 December 2:56  $P^M$ Delores A. Haley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll County Hospital Center Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗓 🛛 Hours 11/06/1950 Virginia **Director** 61 228-78-3976 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 XNo <u>Maryland | Car</u>roll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 1539 Ridge Road 21157 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 K Married þ 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Mindical any injury or other traumatic event, the Mindical 16a, Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Office<u>Manager</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Betty Virginia Burrier Arthur Lee Marsden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .539 Ridge Road Westminster, MD 21157 Michael S. Haley/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ★ Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 12/23/2011 | Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Fort Lincoln F.H. 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final 0 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 10 90 Sequentially list conditions, Examine if any loading to immedicause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown detached 9 Unknown P.0. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed pleted filled in by the funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has autopsy performed? Yes 2 No certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 TINO Certificate: To Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 🗐 No Investigation 6 Could not be 2 Accider
3 Suicide Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number.

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After to ompleted filled in by the funera the

31. Date filed (Month, I State Registrar

Medical

4 Homicide

29a. Certifier

(Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last 2. Date of Death Physician/ Month Year Sidney Jerome Hopkins, Sr. Necember 201 Medical acility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MINAL HICOMICO SAUSBULU If Under 24 Hrs. If Under Birthplace (State or Foreign Country) . Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 214-60-7743 Director 1**X** M 2 □ F 58 Usual Residence of Deced August 20, 1953 Maryland works. 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d, Inside City Limits Director 28a-f 1 ☐ Yes 2X No MD Mardela Springs Wicomico 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a USA 11820 San Domingo Road 21837 items 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces Black, White, etc. ō 1 Never Married 2 X Married þ ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) J.G. Townsend, Jr. & Elementary/Secondary (0-12) College (1-4 or 5+) 9th Refrigeration Operator Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is more any injury or any inju Alice Elizabeth Brown George Edward Hopkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11820 San Domingo Road- Mardela Springs, MD 21837 Rebecca Caroline Hopkins/ Wife 20a. Method of Disposition 20b, Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1  $\boxtimes$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4 Donation 5 Other (Specify) Dec. 10,2011 Zion UMC Cemetery Sharptown, MD sign ture | f Funera Service Licensee Salisbury, Maryland Thanel - 1213 Jersey 22. Name and Address of Facility Road 21801 Jolley Memorial Chapel -23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. . Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death epatorma Physician disease or condition Medical resulting in death) afocellular Carcinoma Examiner anced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami burial-transi that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 month 1 Yes 2 No Month Day Year Pregnant at time of death signed by the a ld be detached f Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown been signal Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2: has autopsy performe death? certificate 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27, Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of I Director: After the funeral 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No hours after death Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier etely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature nd title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month

NGAIZA

of person who completed cause of death (Item 23a) (Type, Print

USTINIAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42304 State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JAY CHARLES HARDY 2011 8:26 A 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 401 Broadway Street Allegany Cumberland Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 **X** M 2 □ F Months Country) Ohic 57 0670571954 Director 213-50-7642 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1X□ Yes 2 □ No MD Cumberland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 401 Broadway Street 21502 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. If Yes Give White 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Railroad Line Foreman 1 and 2 should be filed withi f Health and Mental Hygien item 27 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Junior Hardy Beatrice Lenor Beachy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 401 Broadway Street, Cumberland, MD Melanie Hardy / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ott cemetery, crematory or other place) 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State Sunset Memorial Park 12/14/2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Upchurch Funeral Home, P.A. 21, Signature of Funeral Service Licenses 202 Greene Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failule. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 - Fetal death in the past 12 months? Month Dav Year Pregnant at time of death ed by the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes ြု 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA Virtin 24 hours after deam.

To the Funeral Director: After this commoleted filled in by the funeral di 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Man of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only sne). Gartifying Nurse Frantioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D14865 12/10/2011

State Registrar Jr., M.D. - 200 Glenn Street, Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Robustiano J. Barréra,

31. Date filed (Month, Day, Year)

OEC 12 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 14, 201 Physician/ 9.SSPM Medical 4a. Facility Name (if not institution, give street and number) Examiner County of Peath Maryland Lealth Care eci env oint 8. Date of Birth
(Month, Day, Year)
July 15,1926 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (he vrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 ▼ M 2 □ F Days New York 85 118-16-6264 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Harford Havre de Grace 1 X Yes 2 ☐ No Maryland 10e. Street and Number b 10f. Zip Code 10g. Citizen of What Country? Funeral Items 23a 322 North Union Avenue 21078 U.S.A. 12. Was Decedent Ever in U.S 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. o, 1 ☑ Yes 2 ☐ No Henry, Duane A |A| 3altimore, Maryland 21215-0036 þ 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: and Mental Hygiene. is marked other than "natural", Specify: 3 Widowed 4 Divorced White Completed Year or Dates. WW II 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Henry Advertising Elementary/Seconday (0-12) College (1-4 or 5+) Havre de Grace, MD Twelve Years Owner/Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LoNorah Cooley Howard Henry permit. Page 1 and 2 should be Department of Health and Meni Important; If item 27 is marke any hjury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christianne L. Henry (wife) 322 North Union Avenue, Havre de Grace, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Havre de Grace, 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Angel Hill Cemetery 12/21/11 4 ☐ Donation 5 ☐ Other (Specify) Maryland Sign ture of Funeral Service Ligensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903-0 Shoners 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 PSIS Physician, disease or condition Medical resulting in death) Due to (o) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Examine Due to (or as a consequence of): burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No detached for Month 9 Unknown g 🗌 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? death? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 X No Other: P 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Rodh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sodhi, M.D., Va Nany land Health Care System, Perry 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Charles E. Jenkins 2011 15 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner **Allegany** Frostburg WMHS Frostburg Nursing& Rehah If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday Birthpiac , Country MD 1 🔀 M 2 🗆 F Feb 14 1939 Director 220-34-1755 Show 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location death with the Maryland Director LaVale MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21502 930 Center Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white "natural", 3 Widowed 4 Divorced Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter's Local 1024 carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Martha Kelly **Edward Jenkins** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 930 Center Street LaVale N 19a. Informant's Name/Relationship (Type, Print) MD 21502 Carol Jenkins wife 20b. Place of Disposition (Name of cemetery, crematory or other a 20a Method of Disposition 20c. Location - City or Town, State Date 10 F 10 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cooks Mill Cemetery Department of Important: If any injury or 12/21/20 PA Stringtown Signature of Funeral Ser ce Licensee 22. Name and Address of Facility Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, lary, leading to incredit cause. Enter Underlying Cause (Disease or linjury that initiated events Durinto for este do maquerida of Examin been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be.
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 4 ☐ Pregnant g ☐ Unknown 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autop-performed After this certificate has funeral director, page 2: 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) မ 1 🗌 Yes 2 **Y**No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Accider 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the caus 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 0 0 who completed cause of death (Item 23a) (Type, Print) op Walsh Road Cumberland, MD 21502 State Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Modical Exam	iner			Marie Johnson							14, 2011	ai	1547 hrs
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Funeral		5. Social Security Numb			e (In yrs. last	t birthday)	If Under 1 Y Months D	ear If Und		B. Date of 8 int	h(MM/DD/YYY	Y) 9. 8irt	thplace (State or
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hour:	9	15. Decedent's Educati				<ol><li>6a. Decedent' during mo</li></ol>	s Usual Occup st of working li				16b. Kind of B	usiness/li	ndustry
5-0036 led within 72 hours after death with the Maryland tygiene. other than "aatural", or items 23a or 28a-f she the Medical Examiner must be notified at occe	Completed	Elementary/Secondar	y (0-12)	College (1-4 or	p+)	Wait	ress				Food :	serv:	ice
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	BeC	Walter Mau		nson, Sr						anklin		2)	
21215-0036 ould be filed within 7 IMental Hygiene. marked other than ic evect, the Medical	.0	19a. Informant's Name/R		•		19b. Mailing	Address (Str	eet and Nur	mber or Rura	al Route Numi	ber, City or Tov	vn. State	Zip Code)
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ore, MC ss 1 and 2 s of Health au L'item 27		20a. Method of Dispositi				ce of Disposit		cemetery,		ate	20c. Location	- City or	Town, State
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Balti permit. Departu Import		500	CD	_ ( ) N	100522	THE	Isley-	Johnso	on FH	& Cren	nation (	Cente	er 25411 1055
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Box 68 e death certifi the attending ed for use as	Physician	1 Yes 2 No 9	A Halamana	4 Pregnant at	time of death		(Specify)				ì		
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ViS or At Pired in by	<u>ij</u>	3 Suicide 6 🛭	_	28e. Place of In	ury - At home	e, farm, street,	factory, office	building, et	c. 28	Location (St	reet and Numb	er or Rur	ral Route Number, City r Street Rd
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physiciae: The law requires that the death certificate be within 24 hours after death.  To the Fuorral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buril.		(		To the best of my									
To the Hos within 24 h Fo the Fug completely	Medical	2 4	an	n the basis of exar d manner stated.	nination and/	or investigatio	n, in my opinio	on, death oc	curred at the	e time, date a	nd place, and c	lue to the	cause(s)
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7	[	Patricia Aronica		Assistant M	edical Ex	aminer 9	00 W. Balt	imore Str	reet, Balt	imore, MD	21223		
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Regist	ĕΓ	JAN 11 4 20	114 Char	was B.	Marian	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Lillie Mae Justice 2011 Medical ovember 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula Regional Medical WICOMICO 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** If Under 24 Hrs Months Hours Director 1 □ M 2 🗶 F 83 1-18-1928 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Funeral Director notified 28a-f 1 Yes 2 XNo VA Accomack Temperanceville 10e. Street and Numbe 0 10g, Citizen of What Country? must be 23a 7047 Chincoteaque Lane 23442 USA death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ori by 1X Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No Specify: SpeciBlack "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than ' Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the 8 Poultry Line Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I မ William Justice Mary Nock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Lara Dale Justice/Son 6952 Callahan Circle, Fayetteville, NC 28314 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important; If ite any injury or ott Date ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Jerusalem Bapt Cem12-4-2011 Temperanceville,VA Signature of uneral Service Licensee 22. Name and Address of Facility 917 W. Bennie Smith Funeral Home Salisb Isabella St. Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ ASCNO Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has to the Funeral Director: After this certificate has to the funeral director, page 2 ? performe 2 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No ည 1 Inpatient 2 XER/Outpatient 3 IDOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medican Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated deritiving Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only o 29b. Sig*n*a 2 11 who completed cause of death (Item 23a) (Type, Print) e/and address Chis 2.0. 100 E CARROLL

State Registrar 11-09101 Josiah Johnson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

osiah Johnson	1- For		Si	ate of Maryla		artment of		Mental F		Reg. No. 2		4230
Physician Medical Examine	*	Decedent's Name (First, Middle, Last)						2. Date of Death 3. Tim			3. Time o	
		a. Facility Name (if not institution, give street and number) Peninsula Regional Medical Center					4b. City, Town, or Location of Death Salisbury			4c. County o		
Funeral Director		al Security N 213-91-9		6. Sex	7. Age (In yrs. I	ast birthday) Yrs	If Under 1 Year		_	irth(MM/DD/YYYY) )7/2011	9. Birthplace (St Foreign Country)	ate or
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DIVI To the Hospital or within 24 hours after To the Funeral Dir completely filled in	1 29a G	only 2	Medical Exa	hysician: To the bes miner:On the basis of and manner s	of examination a							
	La	gnature and t	Four	hall m	<u>)</u>		29c. License O.C.M			29d. Date signe December 4	d <i>(Month, Day,</i> Ye	ear)
	Pa	mela E. S	outhall, N		Medical Exa	miner 900	W. Baltimore	Street, Balt	imore, MD 2	1223		
State Registra	e 31. Dat Ir	e filed (Ment	Pay Year)	2011	egistrar's Signatu	A. Sacr	Ke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 2145 V. Ethel Jenkins December 14,2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wisbury Rehabilitation a Nursing Ctr.
Social Security Number 6. Sex 7. Age (In vrs. last birthday) Wicomico 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F Months Director 220-28-4957 78 8-10-1933 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dival Examiner must be notified at 1 X Yes 2 □ No Director MDFruitland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21826 USA 212 Green Street, P.O. Box 340 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 ☐ Yes 2 💢 No Specify Specify: White þ 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I Crouch ျ Raymond Ruark Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Smith - Daughter 204 Hall Drive, Salisbury, Maryland 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crematory of Delmarva 12-16-2011 Delmar, Delaware 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licenses 705 E. Main Street, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cads, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician la tatate Indonetra resulting in death) edical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy jo in the past 12 months? Month Dav Year 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was ... autopsy performed? Yes 2 No the funeral director, page 2 certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

hours after death uneral Director: within 24 hours a To the Funeral I Hospital completely

Registrar

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

32. Registrar's Signature

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Boroduna

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

(enyon Jones,	1- For State Certificate of Death								011 4231	
Physic Medical Exam			I. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year							3. Time of Death
		4a. Facility Name (if not institution, Prince George's County	_	ber)		4b. City, Town, or Cheverly	Location of Dea		4c. County of Prince G	
Funeral Director			5. Sex 7.	. Age (In yrs. I	ast birthday)	If Under 1 Yea Months Days		rs. 8. Date of B	irth(MM/DD/YYYY) /1973	9. 8irthplace (State or ForeignWashington Country) DC
and f show any	ō	Usual Residence of Decedent  10a. State 10b. County  MD Princ	e George's		Town or Locati			<u> </u>		10d. Inside City Limits 1 \( \bigvee \text{Yes} 2 \in \text{No} \)
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 1318 IronForge	Road			10f. Zip Code 20747			10g. Citizen of What United S	
s after death iral", or iter	by Funeral	11. Marital Status 1 Never Married 2 Man 3 Widowed 4 XDivor 15. Decedent's Education (Specif	1 Yes	ces? 2 No	1f Yo	s Decedent of Hises, specify Cuban  Yes 2 X No t's Usual Occupat	specify:	to Rican, etc.)	o- 14. Race - White, Specify: 16b. Kind of Bus	Black
15-0036 filed within 72 hour Hygiene. d other than "natu	Completed	Elementary/Secondary (0-12)	College (1-4			ost of working life.				f Public Works
21215-0036 suld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle, L Dexter Jones					Lanita	Thornt	Maiden Surname)	
B # # # #	T.	19a. Informant's Name/Relationship Lanita Thornton 20a. Method of Disposition		-	1318 1		e Rd. Di			, State, Zip Code)  MD 20747  City or Town, State
	Į,	1 Burial 2 Cremation 4 Donation 5 Other Spec	cify:	State	crematory or oth	erplace) 1n Cemet	tery 12	2/29/201	Brentwo	ood, MD
		21. Signature of Funeral Service Line Than 22.  23a. Part I. Enter the Jisease, or co	-11-	sed the death	340	1 Blader	nsburg	Rd. Br		MD 20722
Physician \ /Medical \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		failure. List only one cause or Immediate Cause (Final disease or condition resulting in death)		Arrhyt	hmia	o mode of dying,	Sucr us cardiac	or respiratory an	rest, shock, of freat	Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate	b. <b>Hyperten</b> Due to (or as a co	sive C	ardiova	scular D	isease			
recuted and - transit	Exami	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of	f):					
D, be es siciar urial	Redical	■ UNPENDED  IF FEMALE:	AMENDED 23			per me,g	924 2-3	-12 sm	I 22d Date of d	lolivon
Box 68760 e death certificate the attending physel for use as the bh	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant 9 Unknown	n t at time of dea n	2 Feta	al death 3 [ er (Specify)	Ectopic pregr	nancy	23d. Date of d Month	Day Year
s, P.O.  Lires that that signed by d be detach	á	Part II. Other significant condition  Diabetes Melli				nderlying cause gi	iven in Part I.			ute to the cause of death?  Probably 4 Unknown
of Vital Records, P.O. ng Physician: The law requires that it ther this certificate has been signed by meral director, page 2 should be detac	Completed	25. Was case referred to medical				OC Plane	of Dooth (Observed)	1 🗸 Yes	osy pri orm <u>ed</u> ? de	ere autopsy findings available for to completion of cause of eath?  Yes 2 No
<b>–</b> ਵੀ . ``ਦ	tion: To Be	examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 ※ Natural 5 Pending	28a. Date of (Month, Da	Injury	ER/Outpatient 28b. Time of In	3 DOA (jury 28c. Injury	of Death (Check Other 1 Nursi y at Work? es 2 No	ng Home 5	Residence 6 how injury occurred	Other:
Division  To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: A completely filled in by the fin	Certification:	2 Accident Investig 3 Suicide 6 Could n 4 Homicide Certifier	ot be 28e. Place o	f Injury - At ho	ome, farm, street	, factory, office bu	uilding, etc.	28f. Location ( or Town, \$		or Rural Route Number, City
To the Ho within 24 l To the Fu	Medical	(Check only one) 1 Certifying Physical Examination (Check only one) 2 Medical Examination (Check only one)	siclan: To the best of ner:On the basis of e and manner state	xamination ar						
	Σ	29h Gianature and title of certifier	te Ver	26-1	300	29c. License O.C.N			29d. Date signed December 2	1 (Month, Day, Year)
R			Assistant Medic	al Examin	er 900 W.	Baltimore St	reet, Baltimo	ore, MD 2122	23	
St Regist	ate rar	31. Date filed (Month 19a2)	32. Règis	trar Signatu	ares					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month KATHLEEN DECEMBE 2011 JAMES Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 7. Age (In yrs. last birthday) 78 yrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Sept 18 9. Birthplace (State or Foreign Funeral 220-28-6627 Days Hours 1 - M 2 1 F Clarksburg, MD Director Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director PA Adams Fairfield 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 17 Main Trail 17320 USA hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. þ 1 Never Married 2 Married "natural", or Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. White Specify: 3 √ Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11 Animal Caretaker Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked or မ Ethel Mav Edward Moran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important; If item 27 is any injury or other trau 17 Main Trail, Fairfield, PA 17320 Dianna Zimmerman, Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State Resthaven Mem. Gardens 12-22-2011 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility 21. Signatur JL Davis Funeral Home Zee 2525 Bradbury Ave., Smithsburg, MD 21783 23a. Part (Eher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ in ultifocal into are al hemanhae disease or condition ) Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on). Examir executed Metastatic lian tube cancer burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be 3 days Deep venous thrombosis Division of Vital Records, P.O. Box 68760 the ate has been signed by the attending page 2 should be detached for use as: IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month Month Pregnant at time of death Hnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? Director: After this certificate 1 ☐ Yes 2 🗷 No 1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) To the Hospital or within 24 hours at To the Funeral D Medical

10 State 29a. Certifier

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ishaar

29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009 gistrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

rederick MD 21701

29d. Date signed (Month, Day, Year)

12/19/11

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 201<sup>Year</sup> 5:15 a. M James Key Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Silver Spring Holy Cross Hospital Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 90 Months Days Hours Min (Month, Day, Year 2/08/192 248 14 2565 North Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo Mitchellville 1 Yes 2 No MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20721 United States 1521 Kings Hall Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14 Race - American Indian. Armed Forces?
1 

Yes 2 □ No Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Specify: Black 3 Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Walter Reed Army Elementary/Seconday (0-12) College (1-4 or 5+) Medical Center Chef 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alice Elizabeth Perry James Ingram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8000 Norwich Court, Port Tobacco, MD 20677 Stacey Crooks Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Brentwood, Maryland Ft. Lincoln Cemetery 12/16/2011 4 Donation 5 Other (Specify) Si ure of uneral Service Cicensee 22. Name and Address of Facility John T. Rhines Funeral Home Washington, DC 20017 3005 12th Street, NE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Cardio Respiratory Arrest resulting in death) Aspiration Pneumonia Examine Physician/Medical Completed by

Physician Medical **Examiner** 

**Funeral** 

Director

ral", or items 23a or 28a-f shov Examiner must be notified at

0.

"natural".

permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical.

death

72 hours after

Baltimore, Maryland 21215-0036

physician and s the burial-trans has this within 24 hours a er de th.

To the Funeral Director: Af

To Be

Certificate:

Medical

only one) 29b. Signatur

filed (Month, Day, Year)
DEC 2 2 2011

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):										
	d									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)		23d. Date of delivery Month Day Year							
Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?							
Cachexia		1 🗆 Yes	2 ☐ No 3 ☐ Probably 4 🐔 Unknown							
Severe Protein Ca	alorie Malnutrition	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?							
Dysphagia		performed?								
25. Was case referred to medical examiner?	26. Place of Death (Check	k only one)								
1 ☐ Yes 2 █ No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho	ome 5 🗀 Residence	6 ☐ Other (Specify)							
27. Manner of Death  1	28a. Date of injury 28b. Time of 28c. Injury at work?    M	28d. Describe how injury occurred								
3 Suicide 6 Could not be 4 Homicide determined	nd Number or Rural Route Number, te)									
	ician: To the best of my knowledge, death occured at the time, date and place, an									

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D63579

29d. Date signed (Month, Day, Year)

12/09/2011

20910

State Registrar

Hospital

32. Registrar's back

30. Name and addiess of person who complete beause of death (Item 23a) (Type, Print)

Maria J. Tayag 1500 Forest Glen Road, Silver Spring, Maryland

My

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 14, 2011 10:08p <sup>M</sup> Anne D. Knight Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** Prince George's 1306 Alberta Drive Forestville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) Director 1 M 2 🔀 F 226-34-7496 March 16,1929 Faber, V.A. show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD Prince George's Forestville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1306 Alberta Drive 20747 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 

Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th Federal Government 12 Recreation Svc Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ernest Dameron Ethel Mawyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other transcence. Jimmy Knight/ Son 522 Essex Place Frederick, MD 21703 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery 12-21-2011 Brentwood, MD 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of uneral Service 3401 Bladensburg Rd Brentwood MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph<sub>sician/</sub> Leukemia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami requires that the death certificate be executed and I-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Day Month Year Pregnant at time of death 5 Other (specify) the 8 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Anemia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Coronary Artey Disease autopsy page 2 certificate has Yes 2 X No 1 ☐ Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🔀 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 28281 16 2011 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NELSON BENJERS, 913) PISCATAWAY ROAD, CLINTON, MD 80735 State DEC 2 0 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 HELEN December KRUSZEWSKI 1:53 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 □ M 2 🕱 F Months Days Hours April 10, 1921 West Virginia 235-26-9242 Director 90 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick 1 X Yes 2 No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 30 North Place United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ XX Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cosmetology Hair Dresser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ John Carr Laura Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1494 Dockside Ct., Frederick, MD 21701 John Thoresen / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🗓 Cremation 3 🗀 Removal from State Dec. Resthaven Crematory 4 Donation 5 Other (Specify) 2011 Frederick, Maryland eral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ ardiviny disease or condition Medical resulting in death) ue to (or as a consequence **Examiner** Sequentially list conditions if any leading to immediate Examine Due to jor as a control incoch cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month Pregnant at time of death Month Dav Year be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Fibrillahian Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Dernentia 24a. Was an Jas performed? Yes 2 Director: After this certificate I 1 Yes 2 No 25. Was case referred to medical examiner? completed filled in by the funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No မှ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

3X Registrar 29b. Signa

and title of certifier

31. Date filed (Month, Day, Year,

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MD

32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Tolinson Dr, Frederica MD 2170)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Hazel M. Kerr Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Western Maryland Regional Medical Center Cumberland 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F Days Min April 27, 1923 **Director** 88 Pennsylvania 215-20-7396 Usual Residence of Decedent or 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Frostburg Maryland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 80 Mount Pleasant Street Funeral U.S.A. 21532-Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
tant; If item 27 is marked other than "natural", or items luny or other traumatic event, the Medical Examiner m 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🕰 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Completed 3 

Midowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Homemaker Homemaker 12 æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Walter Wingert Hazel Mane Wingert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-Richard Kerr Maryland 286 E. Main Street Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State Cumberland Maryland Cumberland Crematory December 13, 2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hew Ph si ian C Crebri Vascula disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if at yr backing to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of, burial-tran and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown Unknown P.0. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🕰 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No မ 1 🗗 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of contiffe 29d, Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

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Sunil Gupta

31. Date filed (Month, Day, Year) **DEC 1 4 2011** 

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

625 Kent Avenue

32. Registrar's Signature

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Cumberland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42317 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2011 Edith Killian 16 10:30P <sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Elkton Care & Rehabilitation E1kton Ceci1 Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 DM 2 X F Hours Month, Day, Year, 5/16/1922 Country) **Director** 176-20-2940 Yrs 89 Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits **Funeral Director** 1 Yes 2 X No Ceci1 E1kton 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 85 Fieldstone Road 21921 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian traumatic event, the Medical Examiner Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Hervey Congleton Caroline Grose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Killian - son Fieldstone Road, Elkton, MD 21921 other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury or 4 ☐ Donation 5 ☐ Other (Specify) Lawn Croft Cemetery 12/22/2011 Linwood, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, J. mi 259 E. Main Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Break disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by DIABETES MELLITUS 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Ves 2 No Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined thin 24 hours a the Funeral D Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

complete only one) 29b. Signature and title of certifier MID Doc 66733 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PULA ELKTON MD 2192 126 E. HIGH street 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JACK LANE FRANCIS DEC 20 2011 6:45A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 116 HAWTHORNE GREENE CIRCLE LA PLATA CHARLES If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Days Director 579-48-6696 1**X** M 2 □ F 79 DEC.15,1932 WASH., DC 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD CHARLES 1 ¥ Yes 2 □ No LA PLATA 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 116 HAWTHORNE GREENE CIRCLE 20646 U. S. A. death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Examiner Armed Forces Black, White, etc. ō 1 Never Married 2 Married þ 1 ☐ Yes 2 🛣 No If Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 5 ± CLERGYMAN RELIGIOUS MINISTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ORLEY BURDETTE LANE SR. should be FRANCES WADDELL and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 MARTHA A. LANE / SPOUSE 116 HAWTHORNE GREENE CR., LA PLATA, MD 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 g DECEMBER ō \* Department Important: I any injury or once. WASH.NAT.CEMETERY 23, 2011 SUITLAND, MARYLAND 21. Signature of Funeral Service 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ancrec Concel Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examine Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 as the k IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown a Linknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an b Hospital or Attending Physician: The law 124 hours after death.
Funeral Director: After this certificate has b. autopsy performed? Yes 2 No page 2 1 Yes 2 No 25. Was case referred to medica 26 Place of Death (Check only one) Be examiner? Other: ျှ 1 🗌 Yes 2 📑 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 7. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at Natural Accident injury 5 Pending work?
1 Yes 2 No Investigation completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1-🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 To the within 2 To the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 0-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State 4 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 42319 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 201 0320M LONG VELY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Hospice House Harwood Birthplace (State or Foreign Country) 5. Social Security Number If Under I If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 1 Year **Funeral** Months Days Hours Min (Month, Day, Year) 1 M 2 F **Director** 579-36-1101 July 27, 1931 DC Usual Residence of Deceden 80 28a-f show ral", or items 23a or 28a-f shore Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 ☐ No Harwood Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3675 Solomons Island Road 20776 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🕱 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 nan "natural", e If Yes, Give Year or Dates 1 Yes 2 No Specify African Specify: 3 Widowed 4 Divorced Completed Amerian 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Cashier Private other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, should be file and Mental Fis marked of P Clifton Kitt Effie Lou Kitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 10600 Tottenham Road Cheltenham, Maryland 20623 Cheryl C. Robinson - Daughter Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Harmony 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. HEART FAILURE Immediate Cause (Final CONGESTIVE ACUTE Death .Ph.si.i.n/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DERTENSION YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b director, page 2 sl autopsy perform death? 1 Yes 2 No 1 ☐ Yes 2 ፫ Be 25. Was case referred to medical 26. Place of Death (Check only one) ARECTR MANDRIN Hospital 2 No 1 Yes |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this funeral ( 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 - Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death.

I Director: After the function of the function 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical within 24 hou

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completely fi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier DEFENSE HIGHWAY ANNAPAUM DZIYO)

DHMH 17 Rev 06-2011

State Registrar Name and address of person who completed dause of death (Item 23a) (Type, Print)

32. Registrar's Si

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42320 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Javors Julius Lucas, Jr. 16<sup>Day</sup> Physician/ Dec 2011 12:42 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Cheverly Prince George's If Under 1 Year If Under 24 Hrs. . Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Sept. 30,194 Macon, 259-76-7453 64 Director 1X M 2 □ F show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at by Funeral Director or 28a-f sh notified a MD Prince George'S Mitchellville 1 Xyes 2 □ No 10g. Citizen of What Country? 100-Street and Number 10502 Vista Grande Drive 5 10f. Zip Code er than "natural", or items 23a of the Medical Examiner must be 20721 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Arrived Forces? permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 11 Yes, Give Year or Dates 1970 – 199 2 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Il Hygiene. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Professor PVT. Be 17. Father's Name (First, Middle, Last) Javors J. Lucas, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H
27 is marked of
traumatic ever ပ္ Mary Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod-07 10502 Vista Grande Dr. Mitchellyille, MD 19a. Informant's Name/Relationship (Type, Print) t of Health a Dora B. Lucas/ Wife other t 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of ö Department c Important: If any injury or once. CHESAPEAKE CREMATORY 12/23/11 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Pridgen Funeral Service, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 9013 Annapolis Rd. Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Ph<sub>sician/</sub> disease or condition resulting in death) Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine the attending physician and ched for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

2 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year detached 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Hospital or Attending Physician: The law requires 24 hours after death.

Funeral Director: After this certificate has been sign 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of Was an this certificate has autopsy perform death? Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: 2 🔀 No 1 🗌 Yes 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital of within 24 hours a To the Funeral D 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or e and title of certifi 29b. Sign son who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Lewis Sr. 2140 M Robert Μ. 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** icon Kegional Medical Cente 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under **Funeral** Days Director 214-60-8597 1 🕱 M 2 🗆 F 59 12/14/1951 Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatht and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Wicomico Delmar Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21875 USA 29935 Connelly Mill Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?
1 

Yes 2 □ No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White 3 Divorced 4 Divorced Year or Dates Army 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Poultry Grower Poultry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Robert William Lewis Margaret (unknown) b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29935 Connelly Mill Rd., Delmar, MD 21875 19a. Informant's Name/Relationship (Type, Print) Polly Lewis/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 
Burial 2 
Cremation 3 
Removal from State 4 Denation 5 Other (Specify) 12/15/2011 Salisbury, MD Salisbury Crematory eture of Funeral Service PHOTIOWAY PURERAL Home Professional Association -501 Snow Hill Rd., Salisbury, MD 21804 t. Enter the disease, or complications that out ock, or heart failure. List only one cause or each l d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician/ COPD ease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami requires that the death certificate be executed and I-tran: Due to (or as a consequence of) resulting in death) Last burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 Yes 2 g g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 Yes 2 No Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Yes 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1/S certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 | Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signatu 15/1 (PM641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E Carroll Street Salisbury MO 21801 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month 2011 02.5 Medical am acility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 544156414 HICOMICO REGIONAL MEGICAL NINSULA If Under 24 Hrs. Security Number If Under 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Min (Month, Day, Year) Hours 155-32-5290 **Director** 1 🛛 M 2 🗆 F 7 -1940 or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No mperanc HCComac ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be Is any injury or other traumatic event, the Medical Examiner must be Is Funeral 10273 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 

Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1961-1963 1 Yes 2 No Specify: Specify. 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şecondary (0-12) College (1-4 or 5+) leamsters Union # 701 Uriver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ enhardt Groh John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 🔏 🖰 🦞 🕽 P.O. Box 10273 San 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - Čity or Town, State Date 1 🖫 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Temperanceville, VA Taylor 12-12-2011 Cometery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chincoteagle, VA 23336 amanda C-Salver Funeral Home Inc 63a7 Church St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ todominal Adric disease or condition Medical resulting in death) Examiner astanc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): anding physician use as the burial Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ĵ Month Day Year Pregnant at time of death ed by the a detached f 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed d be det 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was ...
autopsy
performed?
Yes 2 completely filled in by the funeral director, page 2 this certificate has 2 🗌 No 1 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tyes 2 **N**o မ 1 Inpatient 2 MER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within To the 29b. Signature d title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12 9 11 66198 30. Name and address of person who completed cause of dean (Item USTINIAN N. 1 234) (Type, Print) NGAILA IVA 100 E Carroll St. Salisbury MD 2180 egistrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Yvonne Dale Llovd December 2011 8:52 PΜ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington 13524 Little Antietam Road Hagerstown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Age (In vrs. last birthday) 8. Date of Birth 1 M 2 X Hours West Virginia 1071971940 **Director** 232-60-5537 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 13524 Little Antietam Road 21742 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes 2 XNo 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Library Aid Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Charles Winterstine Gladys Smith Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia D. Crowley / Daughter 13524 Little Antietam Road, Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State Cumberland Crematory: 4 ☐ Donation 5 ☐ Other (Specify) 12/15/2011 Cumberland, MD Signature of Funer 1.5e 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition resulting in death) oncrech Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Ent. r Industrial Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day the 1 ☐ Yes 2 ☑ 9 ☐ Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 →No 3 ☐ Probably 4 ☐ Unknown 1 Yes should ! 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has funeral director, page 2 autopsy performe 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: ည doughter's home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Accident
Suicide 2 🗌 No after death Investigation Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a

To the Funeral E

completed filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death only one) occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 41667 12-11 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

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31. Date filed (Month, Day, Year) **OEC 13 2011** 

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32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 2 [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month December 11, 2011 Physician/ 4:00 M Hannah Isabel Lamberson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Egle Nursing and Rehab Center Allegany Lonaconing 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month Day, Year)
May 09, 1924 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** 6. Sex 1 □ M 2 🕱 F Director 220-16-7149 Usual Residence of Decedent or 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Allegany Lonaconing 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 57 Jackson Street 21539 **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes. Give 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien Homemaker Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas Wilson Rebecca Lancaster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Page 1 and 2 sh partment of Health a portant: If item 27 is y injury or other tra 16012 Rockville Street, Lonaconing, Maryland, 21539 Charles Lamberson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott December December crematory or other place) 1 Burial 2 Cremation 3 Removal from State Mt. View Cemetery Moscow Mills, Maryland 14, 2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPSIS disease or condition Medical resulting in death) **Examiner** 3 weeks Stin intection Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-t Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia, Chronic Obstructive lung disease 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Congestive Heart Failure 24a. Was an has tal or Attending Physician: The lar rs after death. al Director: After this certificate haved in by the funeral director, page 2 performed? Yes 2 12-N 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🔀 No ဂ္ဂ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled i Hospital Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nerse Practioners To the best of my knowledge, death oncurred at the time, date and place, and due to the raisse(s) and manner as state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 021488 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NRS J. Derlin 20 Douglas Ave MD Lenaconing, 31. Date filed (M . Registrar's Signature State 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eva Lee Lucas Ρм 2011 December 5:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's 4603 Hamilton Street Hyattsville 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Hours Director 1925 Washington, DC 578-22-1943 86 March 18. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince George's Hyattsville 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be a Funeral 4603 Hamilton Street **IISA** 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. if tem 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give Year or Dates Specify: African-American 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Department of Health life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Human Services Word Processor 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lee Taylor Esther Omega Dillion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendolyn E. Rivers / Daughter 4603 Hamilton Street, Hyattsville, MD 20781 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 12/15/11 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Rogens Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph\_sici\_n End Stage Senile Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be P.O. Box 68760 the IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death the 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 2 X No 1 🗌 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🔀 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 🛛 Residence 6 🗌 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury death. 1 ☐ Yes 2 ☐ No Accident Suicide Investigation neral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined hours Funeral Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of certifier

DEC 1 9 2011

31. Date filed (Month, Da

Jocelyne

Jocelyne Toukep Kouatchou, 201 E. University Parkway, Baltimore, MD 21218

063748

Koualchou, MI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d Date signed (Month, Day, Year)

December 14, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Physician/ Ronald Mixter 10 10 2011 DCC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Mamland Medical University 01 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours 212-48-5503 Director 1 **X** M 2 □ F March 26, 1947 Maryland 64 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State death with the Maryland Director 1 Yes 2 X No Baltimore Parkton MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 21120 534 Bentley Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White "natural", Completed 3 Divorced the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Beverage Mixologist Be permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant: If item 27 is marriany injury or others. 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ပ Gloria Swanson Hill Elmer Joseph Mixter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 534 Bentley Rd., Parkton, MD 21120 Marsha A. Mixter / Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec Date 28, 1 Burial 2 X Cremation 3 X Removal from State York, PA 17401 Cremation Direct Service 2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. E/-24 N. Second St., New Freedom, PA 17349 luc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final acute dyspnea Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** pulmonam embolism Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death , the a hed fo Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s autopsy perform 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate ∐Yes 2 🗶 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, To Be examiner? 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: 28c. Injury at work? injury 1 Natural 5 Pending Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

• 8gn

Emilie Cobert 22 South Green St. Baltmon MD 21201
31. Date filed (Month, Day, Year)

32. Registrar's Signature

1AN 0 4 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Resident physician

1 solut

Registrar

19735

DEC

2011

23

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH 6923 1/10 Department of Health and Mental Hygiene 2 1

	ı	State	Hof Maryland 96201	artment of Health and N tificate of Death		e 2011 42328
		Registrar  1. Decedent's Name (First, Middle, Last)		uncate of Death	Reg. N	2. Time of Dooth
Physic	ian/	Kevin John Myers	. Sr.		Month Dec. 27,	2011 4:15 A M
Med Exam		4a. Facility Name (if not institution, give street and		4b. City, Town, or Location of Death	Dec. 27,	c. County of Death
Exam	mer	12422 Henry Drive		LaVale		Allegany
Funera	1	5. S909 SecQXV NQП bq 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign
Directo		- 225094-0136- 1 <sup>*</sup> M <sup>2</sup>	53 Yrs.	Months Days Hours Min.	Feb. 12,	1958 Virginia
- MC		Usual Residence of Decedent				
yland f shc	향	10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
Mar 28a-	Director	MD Allegany	LaVale			
th the		10e. Street and Number		10f. Zip Code <b>21502</b>		citizen of What Country?
ms 2 mus	Funeral	12422 Henry Drive	Decedent Ever in U.S. 13. \	Was Decedent of Hispanic Origin? (Spo		14. Race - American Indian,
or ite	by Fi	Arme	d Forces?	f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
s afte		If Yes	, Give or Dates.	1 ☐ Yes 2 ☐XNo Specify:		Specify: White
natur lical	Completed	15. Decedent's Education		dent's Usual Occupation	16b.	Kind of Business Industry
in 72 e. nan "	Ĕ	(Specify only highest grade completed in the complete state of the	ge (1-4 or 5+)	O NOT use retired)		
Vgien ygien her ti		12	Plum	mer / Self Employ		phalt Seal Coating
tal Hydra even	To Be	17. Father's Name (First, Middle, Last)	TTT		ne (First, Middle, Maider	ford) Myers Ford
y d	-	Joseph Plunkett Mye				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)	_	ng Address (Street and Number or Run 2 Henry Drive, La		or Town, State, Zip Code) 21502
and 2 Healt tem 2		Lisa Stanley Myers  20a. Method of Disposition	Spouse   1242			Location - City or Town, State
Page 1. ment of 1 ant: If it	1	1 X Burial 2 Cremation 3 Removal	from State cemetery, crer	natory or other place)		
it. Pa irtmei irtani injury	.	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee			· .	umberland, MD
permit. Departr Importa any inju	3	1 0 0 7 1 1		2. Name and Address of Facility Ha 302 National Hwy.	fer Funera	I Service, PA MD 21502
_		23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause of				Approximate
140		shock, or heart failure. List only one cause of Immediate Cause (Final	AND THE PERSON NAMED IN			Interval Between Onset and Death
⊸Pnysician ⊬ Medica		disease or condition	e to (or as a consequence of):	arcinoma		2009
Examine		Du.	e to (or as a consequence or).			
	je je		e to (or as a consequence of):			
ansit	Examiner	Cause (Disease or iinjury that initiated events				
execu an and ial-tra	Ä		e to (or as a consequence of):			
hat the death certificate be executed ed by the attending physician and detached for use as the burial-transit	dical	d				
tificat ng ph as th	Me.	IF FEMALE:		- 177		
h cert tendir r use	an/	192h Mas decedent pregnant 23c. If yes		Ectopic pregnancy	73	23d. Date of delivery
deatl he atl ed fo	Physician/Med	1 \ Ves 2 \ No \ 4 \	Pregnant at time of death 5 [ Unknown	Other (specify)		Month Day Year
at the	E	Part II. Other significant conditions contributing	to death but not resulting in the u	underlying cause given in Part I.	23e Did tobacco	use contribute to the cause of death?
es tha	l by	Tarrii. Other significant contains as any	to dodn't but hot your ling in the	andonying saase given in variation		2 No 3 Probably 4 Unknown
requires requires been signal	Completed					24b. Were autopsy findings available
law r has b e 2 sl	ďμ				24a. Was an autopsy performed?	prior to completion of cause of
The cate	اق				1 Yes 2	
ician certifi ector	Be	25. Was case referred to medical examiner? Hospital:		26. Place of Death (Chec		
Phys this	은		1 ☐ Inpatient 2 ☐ ER/Outpatie Date of injury 28b. Time of	nt 3 🗆 DOA   4 🗀 Nursing H	ome 5 Residence	
ding th. After	cate	1 Natural 5 Pending 2 Accident Investigation	Month, Day, Year) injury	work? M 1 ☐ Yes 2 ☐ No	,	-,
Atten r dear ector:	Certificate:	3 Suicide 6 Could not be 28e. F	Place of Injury - At home, farm, str	reet, factory, office		and Number or Rural Route Number,
al or all		4 - Horricide determined	ouilding, etc. (Specify)		City or Town, Sta	te)
To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending ph completed filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying Physician: To the Control of the Contr	the best of my knowledge, death	occured at the time, date and place, a	and due to the cause(s)	and manner as stated.
he Hk in 24 he Fu plete	Mec	(Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Practio	e pasis of examination and/or inves ner: To the best of my knowledge,	stigation, in my opinion, death occurred a death occurred at the time, date and pla	at the time, date and pla- ace, and due to the caus	ce, and due to the cause(s) and manner stated. e(s) and manner as stated.
Vith Com		29b. Signature and title of certifier	M	29c. License number		Date signed (Month, Day, Year)
1 / AA	M			D0023371	12	/27/2011
4		30. Name and address of person who completed				7.500
		OAMAR U. ZAMAN M.D		BROOK RD, CUMBERL	AND, MD 2	1502
Si	tate	31. Date filed (Month, Day, Mark) 2	32. Registrar Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 14, 2011 Physician/ 2:10 p Daisy W. Myles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Arden Courts of Silver Spring Silver Spring 5. Social Security Number 6. Sex 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 924 Months Days Hours Min Maryland Director 216-22-3541 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d Inside City Limits must be notified at 10c. City. Town or Location Director 1 xxYes 2 ☐ No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 20011 United States 4624 Blagden Terrace NW 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Black, White, etc. ģ 1 Never Married 2 Married should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Laura Harmon Mason J. Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20011 4624 Blagden Terrace NW Washington, DC Matrona L. Snowden - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dec. 21. Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill 2011 Suitland, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Stewart Funeral Home, 20019 4001 Benning Road NE Washington, DC 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it may leading to immediate cause. Enter Underlying Examine Duy to for as a consecution of and I-transit that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?
Yes 2 X No this certificate has Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Assisted Living
4 Nursing Home 5 Residence 6 Other (Specify) examiner? Hospital Other: 2 🔀 No 1 🗌 Yes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 🗷 Natural injury 5 Pending Accident 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital 24 hours after death Funeral Director, To the I within 24

Records, P.O. Box 68760

State Registrar

DHMH 17 Rev 7/2009

29b. Signa

14201 Laurel Park Drive Suite 102

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Armstrong, M.D.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D43237

29d. Date signed (Month, Day, Year) December 19, 2011

Laurel, Maryland

20707

29c. License number

🗆 Contifying Nurse Fractioner Tuith: best of my knowledge, deeth occurred at the time date and place, and due to the cause (ii) and main as state.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ber 2011 105 A Royce H. McDevitt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Doctors Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours 579-38-0467 80 Director Washington, DC August Usual Residence of Decedent show ital Hyglene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 🔀 Yes 2 🗌 No Maryland Prince George's Riverdale 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 5908 Cleveland Avenue USA 20737 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian rmed Forces?

X Yes 2 \( \sum \) No Black, White, etc. þ 1 Never Married 2 Married NAVY Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced WWII White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Printing Book Binder 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Should be Department of Health and Menta Important: If item 27 is marked any injury or other traumation marked ည Royce H. McDevitt Gladys Blacker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7401 Albermarle Drive, Manassas, VA 20111 Robert E. Tennant / Nephew 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 12/21/2011 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 RAY Pages Gasch's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Som Bauch disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of) attending physiclan for use as the buria Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 2 No 1 Tes Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an the Hospital or Attending Physician: The law page 2 s autopsy performe this certificate has HUPOHYRODISM 1 ☐ Yes 2 ☐ No Yes 2 No . Was ca referred to m dical examiner? director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ 1, Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending n 24 hours and control Africation Africation Africation by the fu 1 Tes 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practiciner: To the cause of the course of the time date and place and due to the course of the cause of the course of the c the within **To the** 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) 70 P2222d 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THORNYS 1252 Lensher GREETINA 31. Date filed (Month, Day, Year DEC 2 1 2011 State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:06 Mary McKnight Betty Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Decomico 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, Year) .0/31/1928 1 □ M 2 🎛 F Months Days Hours Min 264-38-6870 **Director** Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director Maryland Wicomico Parsonsburg 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21849 USA 31721 Morris Leonard Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: White Bethy McKnight Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Switchboard Operator Telephone 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Elizabeth Hudson William F. Mumford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 31721 Morris Leonard Rd., Parsonsburg, MD 21849 Vernon H. McKnight Jr/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Salisbury, MD 12/13/2011 Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 ture of Funeral Service Licensee (Hompson CFSP Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CHRONIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examin and -transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burial Physician/Medical Box 68760 attending physic I for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Month Pregnant at time of death the 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 I No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has this certificate 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 ဂ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29d Date signed (Month, Day, Year) 29b. Signati

Registrar

State

31. Date filed (Month

20TE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:58 Annie Lee Miller NOV 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HICOMICO TENIN SULA Mediane Center SALISBUIL ROGIONAL 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral (Month, Day, Year) Hours Min. **Director** 263-78-5817 1 🗆 M 2 🔀 Florida -14-1947 64 Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits at 10c. City. Town or Location Director notified 1 Yes 2 X No VA Accomack Atlantic 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Examiner must be Funeral items 23a 31330 Nocksland Road 23416 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces þ 1 Never Married 2 Married "natural", or ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: SpecB:lack Completed 3 Widowed 4 Divorced event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4 or 5+) Janitorial 12 Services Arcadia High School is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be fill ment of Health and Mental 2 Frank Campbell Mattie M. Robbins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2...
Department of Health and Important: If item 27 is Sonya White/Daughter <u>91, Oak Hall, VA</u> PO Box 23416 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 Depation 5 ☐ Other (Specify) Jerusalem Bapt Cem12-3-2011 Temperanceville, VA 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Home Salisbury, MD 21801 Signatury of Funeral Service Licensee any ir 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CANCER Physician/ METASTATIC Medical resulting in death) Due to (or as a consequence of) Examiner BREAST CANCER Sequentially list conditions, it my leading cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran and Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an thin 24 hours after death.

the Funeral Director: After this certificate has I mpletely filled in by the funeral director, page 2: autopsy perform 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No မှ 1 Yes 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d, Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/26/2011 D72248 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINGH, 100 E CARPOLL ST., SALISBURY, MD 21801

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lichael Thomas		1- For State	State of Mar	yland / Depa	rtment of		Mental H		g. No. 20	11 4233
Physicia		Registrar  1. Decedent's Name (First,	, Middle,Last)				1	2. Date of Deat	h	3. Time of Death
Medical Exami	ner	Mich		nomas	Mel			Month December		1704 hrs
		4a. Facility Name (if not in: Peninsula Region			1	4b. City, Town, or L. Salisbury	ocation of Death		4c. County of De Wicomico	atn
Funeral		Social Security Number		7, Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birt	h(MM/DD/YYYY) 9.	Birthplace (State or
Director		594-62-87	30 1⊠M 2□	F 36	Yrs	Months Days	Hours Min.	4-27	-1975 For	eign Country) VA
		Usual Residence of Deced	dent			J		1 1 4 4		
w any		10a. State 10b. Co		7.3	Town or Locat					10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f show	ģ	10e. Street and Number	ccomack	<u>  Ch</u>	incot	CAAUC 10f. Zib Code		110	og, Citizen of What C	
ne Man or 28	Director	7308 Eas-	+ Side C	١.		2333	31.		U.S.A	-
0036 within 72 hours after death with the Maryland jene. rer than "natural", or items 23a or 28s-f sho Medical Examiner must be notified at once.	ā	11. Marital Status	12. Was	Decedent Ever in U.S		s Decedent of Hisp	anic Origin? ( Sp			nerican Indian, Black,
death or iten	Funeral	1 Never Married 2	1 Ye			es, specify Cuban,		Rican, etc.)	White, etc	
	<u>a</u>		Divorced If Yes, Give or Dates:			Yes 2 X No		adi dono	Specify: W	
5-0036 led within 72 hours after Hygiene. other than "natural",	Completed	15. Decedent's Education Elementary/Secondary (		grade completed) ge (1-4 or 5+)		t's Usual Occupation ost of working life. I			Top. Killa of busines	ss/mausi y
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21215-0036 sold be filed within 7 Mental Hygiene, marked other that is event, the Medica		17. Father's Name (First, N				18	8.Mother's Name		faiden Surname)	
21215-0 ould be filed w marked Hygie e event, the b	Be	19a, Informant's Name/Rel		Melvin	140h Mailine	Addrogs (Street	Lind		b r, ity or Town, St	luin
MD 2 d 2 shoul lith and M n 27 is m	٩	William V		Father			ide Dr	- 1	1	NA 33336
_ C @ M C		20a. Method of Disposition	)	20b. P	lace of Dispos	ition (Name of ceme		Date	20c. Location - City	or Town, State
nor ages ant of l		1 Burial 2 Cree 4 Donation 5 Ott		al IIOIII State	obcoc	iock Crem	در اسلا	- ( 2011	Exmore	. VIA
Baltimore, permit, Pages 1 a Department of He Important: If its injury or other to		21. Signature of Funeral S		1000		ame end Address			oleague, VA	
E P P P	9 2	amanda	e. Bott	دلا	S	alyer Fin	eral Hom	- Inc. i	2327 Chun	h St.
Physician /Medical	8 8	23a. Part I. Enter the disea failure. List only one	cause on each line.							Approximate Interval Between Onset and Death
£xaminer		Immediate Cause (Final di or condition resulting in de		ac Arrhyth		sociated v	with myo	cardial	fibrosis	Death
		Sequentially list conditions	h							
	iner	If any leading to immediate cause. Enter Underlying (	le Diue to (or	as a consequence of	k					
Į.	Examiner	(Disease or injury that initi events resulting in death)	iated c.	as a consequence of)	):					
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O, e be ex rsician burial	edical	X UNPENDED	Later Control	ED <b>23a,pt.</b> I		er me,g92	4 2-13-1	Z SM	Local Barrier	
876 tificate ng phy as the	M	IF FEMALE: 23b. Was decedent pregna past 12 months?	nt in the	res, outcome of pregn ve birth	. —	tal death 3	Ectopic pregna	ncy	23d, Date of deliv	Day Year
Box 68760 e death certificate b the attending physied for use as the bu	sicia	1 Yes 2 No 9	1 Helenoum	regnant at time of dea	ath 5 Ot	her (Specify)				
hed the	Physician/Me	Part II. Other significant of		nknown	sulting in the u	inderlying cause giv	ven in Part I.	23e, Did to	bacco use contribute	to the cause of death?
P.C ss that gned be deta	<u>a</u>		Schizophren			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1 Yes	2 No 3 P	robably 4 🗹 Unknown
rds, P.( requires that been signed hould be det	Completed		-				_	24a. Was autop		autopsy findings available to completion of cause of
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tal Rec cian: The certificate ector, page		25. Was case referred to n				The state of the s	of Death (Check			
Vital   hysician: this certifi I director,	B B	examiner? 1 ✓ Yes 2 N	lo Hospital: 1	Inpatient 2	ER/Outpatient	3 ☐ DOA	Other Nursin	g Home 5	Residence 6 Ot	her:
n of Viding Physical  After this funeral dir		27. Manner of Death  1 X Natural 5	, (N	Date of Injury Ionth, Day, Year)	28b. Time of I			28d. Describe h	now injury occurred	
Sior Attend death cctor:	catic	2 Accident	Pending Investigation	Disease of Laborate At his	form star		es 2 No	29f Location /9	Street and Number or	Rural Route Number, City
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the virthin 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detacted.	Certification:	3 Suicide 6	Could not be determined (Spec	Place of Inju <b>ry</b> - At ho c <i>ify</i> )	me, rarm, stree	et, ractory, office bu	illaing, etc.	or Town, S		Rural Rodie Humber, Oily
the Hospit hin 24 hour the Funer		4 Homicide  29a. Certifier (Check only 1 Certify	ving Physician: To the	best of my knowledg	e, death occur	red at the time, date	e and place, and	due to the caus	e(s) and manner as s	stated.
To the Hos within 24 h	Medical	one) 2 Medica	ai Examiner:On the ba and mann	sis of examination an	nd/or investigat	tion, in my opinion,	death occurred a	t the time, date	and place, and due to	the cause(s)
F S F S	Ž	29b. Signature and title of	certifier			29c. License	000	1E	29d. Date signed (	
		Theodore	M. Kin	of TRus	m, )	O.C.M	1.E.		December 5, 2	
MC		<ol><li>Name and address of p</li><li>Theodore M. King</li></ol>		cause of death (Item istant Medical E	,	900 W. Baltime	ore Street. B	altimore. MF	21223	
	ate	31. Date filed (Month, Day,	yearhous 32	Registrar's Signatur						
Regist		DEC 0	6 2011	wer S.	par	hed				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State Registrar	State of Manyland (Dep Ce	rtificate of Death	Reg.	No. ZUII	4233
		Decedent's Name (First, Middle, Last			2. Date of Death		3. Time of Death
Physic /Medi		Leroy Samuel M	oore		Month 3 (	Day Year 2011	07-50A
Exami		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea	th	4c. County of Deat	
		6682 Forrest G	rove Road	Parsonsburg	V	Vicomico	•
Funeral		Social Security Number     6. Se	שא מוור	If Under 1 Year If Under 24 Hrs Months Days Hours Min	8. Date of Birth 1	939 9. Birtl	nplace (State or Foreiguntry)
Director		215-36-0688	XM 2□ F 73 Yrs.	33,7	5-11-1 <del>93</del>		
pu sud		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ncation			10d. Inside City Limit
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72 hours after death with the Maryland natural; or items 23a or 28a-f show dical Examinar must be notified at	Director	MD Wicomic  10e. Street and Number	o Parsonsb	urg 10f. Zip Code	100	Citizen of What Co	
with la or			-				unby?
leath	Funeral	6682 Forrest G		21849 Was Decedent of Hispanic Origin? (	Specify Yes or No-	14. Race - Ame	ncan Indian.
r Iter	FE	1 ☐ Never Married 2 ☐ Married	Armed Forces?	If Yes, specify Cuban, Mexican, Puel	to Rican, etc.)	Black, White	e, etc.
urs a	by	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates: Army	1 ☐ Yes 2 🌠 No Specify:		SpecifyBla	ck
2 no	Completed	15. Decedent's Edu	cation 16a. Dece	dent's Usual Occupation		. Kind of Business/	Industry
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be rifed tal Hygie d other avent, II	Be (	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maid	den Sumame)	
snould by and Ments a marked	10	Henry McCoy		Mildre	d Laffoss	se	
z should be and Mental is marked ( aumatic av		19a. Informant's Name/Relationship (T)	rpe, Print) 19b. Mail	ng Address (Street and Number or R	ural Route Number, Ci	ty or Town, State, Z	(ip Code)
Health Hem 27 other tra		Jerome Reid/St	ep-son 239	E. Ruark Dr, S	alisbury,	MD 218	04
uges I and 2 should be little than 1/2 hours after beath with the Marylan Ald Health and Mental Hygiene. At of Health and Mental Hygiene. At of Health and Mental Hygiene. Or other traumatic avent, the Medical Examinar must be notified at		20a. Method of Disposition	20b. Place of Disp			. Location - City or	
nent of nent of int: if its		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  1 ☐ Denation 5 ☐ Other (Specify)	removal from State	hip UM Cem12-9	-2011 Qua	antico.	MD
Definit. Pages Department of Important: If Ite any injury or of		21. Signature of Funeral Service Licens	ed 2	2. Name and Address of Facility 0 1	7 W. Isak	ella St	•
Depa Impo any ir		& hund of	9 / 1	ennie Smith uneral Home Sa			
3		23a. Part1. Enter the disease, or compl	ications that caused the death. Do not en				Approximate
hysician		shock, or heart failure. List only o Immediate Cause (Final		1:0 1.1	and-		Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	araiax Inf	A/CUM		mingles
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	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):		-		/ 2013
nd	Examiner	Cause (Disease or injury that initiated events					
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attending p	Physician/Me	200. Was decedent prognant	3c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 3[	Ectopic pregnancy		23d. Date of deli	very
the att	SICIS	in the past 12 months? 1 ☐ Yes 2 ☐ No		Other (specify)		Month	Day Year
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nician requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by F		ntributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
bluods	ed	Diabeles, h	y ferlension, hy fer	Rifedemia,	1 🗆 Yes	2 □ No 3 🖼 Pro	obably 4 DUnknow
as be 2 sh	Completed by	Smoking	•		24a. Was an	24b. Were au	topsy findings available
r this certificate has and director, page 2.9	EO				autopsy performed	? death?	·
	a	25. Was case referred to medical		26. Place of De	ath (Check only one)	10 103	2,00
direc	ToB	examiner?	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	Othor	lome 5 4 esidence	e 6 ∏Other (Spec	erfv)
within 24 hours after death.  To the Funeral Director: After this certific c. mpletely filled in by the funeral director,		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how in		
death. ctor; Af y the fur	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Monal, Day 1 Gai) Injury	M 1 ☐ Yes 2 ☐ No			
er de recto by tr	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, sti building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St		ral Route Number,
s afte	Cert	4 - Normoldo	building, etc. (Specify)		City of Town, Si	1418)	
within 24 hours after death. To the Funeral Director: At	edical	29a. Certifier 1 Certifying Physical Certifying Physical Examination (Check only 2 Medical Examination)	sician: To the best of my knowledge, deat her: On the basis of examination and/or in	n occurred at the time, date and place	e, and due to the cause	e(s) and manner as	stated.
the F	edi	one)	and manner stated.	vestigation, in my opinion, death occi	urred at the time, date	and place, and due	to the cause(s)
ToT	Σ	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month	, Day, Year)
		plus & -	Physician	DO052255	13	2-07-	2211
			1 1 1 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		1 4		
TO (2)		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type,	Print)			
TOPP		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type,	Print) 2/6/3			

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Mar	*			Mental Hyg	giene	
		_	State     Registrar	Cei	rtificate of D	Death	T	Reg. No. 20	11, 42335
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Y	3. Time of Death 1355 M
	Medic Examir	cal	Lula Wyrena Moxey  4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Dea	December	4c. County of	
	Examir	ier	Memorial Hospital at Eas	tan	Easto			Tall	06+
	Funeral			In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h (Year)	9. Birthplace (State or Foreign Country)
	Director		232-52-7879 1 □ M 2 🗓 X F	79 Yrs.	WOILIIS Days	Hours Will	1	3, 1932	Virginia
	how at	=	Usual Residence of Decedent  10a. State 10b. County 1	10c. City, Town or Lo	ocation				10d. Inside City Limits
_	larylar 3a-f s iffied	Director	Maryland Caroline	Preston					1 🗌 Yes 2 🛛 No
3	or 28		10e. Street and Number		10f. Zip Code			10g. Citizen of Wh	
3	s 23a	Funeral	22100 Havercamp Road		21	L655		US	SA
1	death item ner n		11. Marital Status 12. Was Decedent Eve Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indian, White, etc.
36	after al", or xami	d by	1 Never Married 2 Married 1 Yes 2 X No If Yes, Give 3 X Widowed 4 Divorced Yes, or Dates	2	1 ☐ Yes 2 🗓 No	Specify:		Specify:	White
21215-0036	hours natura ical E	Completed	15. Decedent's Education		dent's Usual Occup			16b. Kind of Busi	
215	in 72 e. na <b>n "r</b> Med	ш	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	life D	kind of work done of O NOT use retired)	during most of wo	orking		
7	ygiene ygiene her th t, the		11	Ho	memaker				Home
pue	e filed ttal Hy ed otl	To Be	17. Father's Name (First, Middle, Last) Willie Arthur Long				me (First, Middle, i Sykes	Maiden Surname)	
ž	d Mer mark matic		19a. Informant's Name/Relationship (Type, Print)	405 14-11	A -l -l (C4 4			City or Town Stor	to Zin Cadal
Maryland	2 shoth the and the an		Katrina Thomas/Daughter		ng Address (Street a Gallaghe			-	
re,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition	20b. Place of Dispo	osition (Name of		Date		City or Town, State
шO	Page nent c int: If iry or		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Our Lady (	matory or other place Of Good Cou	mse1 12/	16/2011	Secreta	ry, Maryland
Baltimore,	permit. Departn Imports any inju		21. Signitur, of Fineral Service Ligense	7 1 2	2 Name and Addres	ss of Facility		Box 207	
_	20 E # 9		Trovard or Il		eller Fun 06 Main S				MD 21631
			28a. Part J. Enter the disease, or com dications that caused the shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death
5-1	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	onsequence of):	e Car	ndich	MOPa	464	Offset and Death
	Examiner		Due to (or as	ionsequence of):	e Car	· C · - 4 ·		(E)	
		Jer	Sequentially list conditions, b.	tonsequence of:	3	2, 10	r 100 -		
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387	rtifica ling pl		IF FEMALE:	prograncy					
) XC	eath certifica attending p	cian	In the past 12 months?	Fetal death 3	Ectopic pregnanc	;y		23d. Date Monti	of delivery h Day Year
ĕ.	the a	ysic	1   Yes 2   No 4   Pregnant at the graph of	ille of death 3 L					
P.O. Box 687	requires that the der been signed by the s should be detached	Completed by Physician/M	Part II. Other significant conditions contributing to death but	_			23e. Did to	bacco use contrib	ute to the cause of death?
S,	uires in sign	ed b	Chronic Obstrue	tive Ps	Imena	~~	1 🗆 `	Yes 2□No 3	Probably 4 Onknown
orc	w req	plet	disease			,	24a. Was a		ere autopsy findings available for to completion of cause of
Rec	sician: The law r s certificate has b director, page 2 s	lo m					perfor	rmed? de	ath? □ Yes 2 □ No
_ E	ertifica ector,	Be (	25. Was case referred to medical examiner?		26. Pl	ace of Death (Ch	eck only one)		
₹	hysic this ce al dire	은	1 Yes 2 No Hospital:	t 2 ER/Outpatie		4 U Nursing		lence 6  Other	
וסר	ding P	ate:	27. Manner of Death 1 ☐ ★ atural 5 ☐ Pending 28a. Date of injury (Month, Day, 1)	Year) 28b. Time of injury	work		28d. Describe h	ow injury occurred	
Sio	death death ctor:	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury	- At home, farm, str		res Z L No	28f. Location (S	treet and Number	or Rural Route Number,
Division of Vital Records,	after Direction b		4 Homicide determined building, etc. (		,,,		City or Tow		
	ospita hours uneral ly fille	Medical	29a. Certifier 1 Certifying Physician: To the best of my						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.  Within £4 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic	Mec	(Check 2 Medical Examiner: On the basis of examiner only one) 3 Certifying Nurse Practitioner: To the b	pest of my knowledge	e, death occurred at t	he time, date and	place, and due to ti	he cause(s) and mar	nner as stated.
-			29b. Signature and title of certifier		29c. License	number		29d. Date signed (	
	0		( ) or ( ) the les	vin		5311	0	Jecen	16er 12 2011
		ĺ	30. Name and address of person who completed cause of dear Dennis M. DeShields, M.D.,			n Street	, Easton	, MD 2160	01
	Sta	e		s Signature	1 4 1				
1'-	Registr		UEC 1 4 2011 / Manua	L H. A	arte				

DHMH 17 Rev 06-2011

		Please T	ype or Print in				-		gible.	
	-	For State Registrar	State of Marylar		artment of t tificate of l		лептат ну	rgiene Reg. No. 2	0.1	1 1.2220
Physician	,	1. Decedent's Name (First, Middle, Last)					2. Date of De	eath	Voor	3. Time of Death
Physiciar Medica	al	MADELINE TRANUM M			<u> </u>		12		2011	7:20 P. M
Examine	er	4a. Facility Name (if not institution, give str 15301 McMullen Hi			4b. City, Town, o	r Location of Death		- 1	nty of Deat 11ega	
Funeral Director		5. Social Security Number 6. Sex	M 2 7. Age (In yrs. 1	• •	If Under 1 Year Months Days		8. Date of Bit 11/11/	rth	9. Birt	thplace (State or Foreign untry)
how at	۲	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Loc	cation					10d. Inside City Limits
/arylar 8a-f s tified	Director	MD Allegan		resapto						1 🗆 Yes 2 🛣 No
h the had a or 2 be no	a	10e. Street and Number			10f. Zip Code			10g. Citizen o		untry?
ms 23	Funeral	15301 McMullen HI	ghway  2. Was Decedent Ever in U.	6 T10 W	2150	)2 lispanic Origin? (Spe	noify Von or No		S.A.	
or ite	by Fe	11. Marital Status 12 ☐ Never Married 2 ☐ Married 13	Armed Forces? 1 ☐ Yes 2 👿 No	If	Yes, specify Cuba	an, Mexican, Puerto			lack, White	
urs aff tural", al Exa	ted	3 XWidowed 4 Divorced	Year or Dates.	1	☐ Yes 2 🛣 No	Specify:		Specia	hite	
72 ho n "nat /edica	Completed	15. Decedent's Educ (Specify only highest grade	completed)	I (Give k	lent's Usual Occup kind of work done ( O NOT use retired)	during most of work	ing	16b, Kind of	Business	Industry
within giene.	ဒ္ဓိ	Elementary/Seconday (0-12)	College (1-4 or 5+)	1	eacher			Edi	ucati	lon
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) Grover Tranum		_		18. Mother's Nam Helen	e (First, Middle Spiker	, Maiden Surnar	ne)	
shoulk and N is ma rauma		19a. Informant's Name/Relationship (Type		1		and Number or Rura				
and 2 Health tem 2	-	Delores Rinard / 20a. Method of Disposition			Z N. Cent sition (Name of	re Street	Date	erland,		21502
age 1 ent of nt: If if		1  Burial 2  Cremation 3  Re 4  Donation 5  Other (Specify)	emoval from State	cemetery, crem	Meml.Pa	ce)	9/2011	1	-	and, MD
Departm Departm Mporta any inju		21. Signature of Funeral Service Licensee	4	22	. Name and Addre	ss of Facility Upc	hurch F	uneral	Home	, P.A.
22 2 10 01	$\dashv$	23a. Part 1. Enter the disease, or complic	40 4			ne Street			עוא	21502 Approximate
Physician/		shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	7	,		, , , , , , , , , , , , , , , , , , , ,			Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence	uence of):					$\neg$	2006
	<u>ا</u> ۾	Sequentially list conditions, b.	HTN						$\rightarrow$	2006
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ate be	gica   Gica	d.							$\longrightarrow$	
ding p	ğ	IF FEMALE: 23b. Was decedent pregnant 23c	c. If yes, outcome of pregna	ancy				224 [	Date of del	iven
death c	by Physician/Medical	in the past 12 months?	1 Live Birth 2 Feta 4 Pregnant at time of a 9 Unknown		Ectopic pregnand Other (specify) _	су			Month	Day Year
at the d by the etache	Phy	9 ☐ Unknown  Part II. Other significant conditions conti		sulting in the ur	nderlying cause di	ven in Part I	22a Didd	tobacca usa cor	ntributa ta	the cause of death?
signer d be d	d b	Recent Sumber			10/11	YOUTH CARCIT		_	•	robably 4 🗆 Unknown
v requ	) Sete		/				24a. Was		. Were aut	topsy findings available
The lay	Completed						auto perfe	ormed2 2 No	death?	completion of cause of
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ath. r: Afte	cate	1 ☑ Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	(Month, Day, Year)	injury	work		200. Describe	now injury occu	iled	
	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		et, factory, office		28f. Location ( City or To		ber or Rui	ral Route Number,
Hospita 24 hours Funera sted fille	Medical	(Check 2 Medical Examiner	an: To the best of my know On the basis of examinatio	n and/or investi	igation, in my opinio	on, death occurred a	t the time, date :	and place, and d	due to the o	cause(s) and manner stated
o the		29b. Signature and title of certifier	Preathoners To the best of m	y knowledge. d	29c. License		te, and due to th	29d. Date sign		
		Muy & Hard	ey CRINT		RUS	9699-11	2	_	6/20	
20		30. Name and address of person who com	pleted cause of death (Item	, , , , ,	,		<u></u>			
State		Terry E. Harvey, 31. Date filed (Month, Day, Year)				perland, N	MD 215	02		
Registra	r	31. Date filed (Month, Day, Year) OEC 19 2011	32. Registrar's Signa	and were						

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month <sup>Day</sup> 08 2011Mandell Weslev December 6:00 A. Corbin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Bowie Larkin Chase Nursing Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days Hours Min. 07/109/1927 1 🕅 M 2 🗆 F 84 Texas Director 525-50-2814 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** notified 28a-f 1 🗆 Yes 2 💢 No MD Prince George's Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be r 6307 Croom Station Road 20772 U.S.A. should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Iryland 21215-0036 If Yes, Give Year or Dates. 1944–74 1 Yes 2X No Specify: 3 Midowed 4 □ Divorced Specify: white "natural" Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the master chief engineman U.S. Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic even ဂ Darwin Casad Mandell Mary Corbin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 2911 Heather Court, Chesapeake Beach, MD 20732 Ann Marie Smith, daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If if any Injury or c 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 12/10/2011 Alexandria, VA ture of Funeral Service Licen 22. Name and Address of Facility Rausch Funeral Home, P.A. Harmony Lane, Owings, MD 23a. Part 1. Inter the ris-shock, or heart fillu Immediate Cause (Fina Approximate Interval Betweer Onset and Death Physician/ disease or condition resulting in death) hours *∱* Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami attending physician and for use as the burial-transit Due to (or as a consequence of resulting in death) Last Physician/Medical Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide Investigation Divisio 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier on who completed cause of death (Item 23a) (Type, Print)

State Registrar

		For State Registrar	Pleas	State of M		id / Depa		Health and N	/lental Hyg	jiene	egible.	1 4233	3 1
Physicia Medic		1. Decedent's Nam	ne (First, Middle, L Melvin	ast)					2. Date of Dea Month		Year 2011	3. Time of Death	
Examir		Shady Gr	ove Hosp				Gaither				unty of Death		
Funeral Director		5. Social Security N 579-52-80 Usual Residence of	061	Sex 7. A	ge (In yrs. la 75	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 08-31-	Year)	9. Birth Co <i>ui</i>	nplace (State or Foreign ntry) NC	7
Maryland :8a-f show	rector	10a. State	10b. County  Montgom	ery		y,Town or Loc						10d. Inside City Limits	
with the lis 23a or 2	Funeral Director	10e. Street and Nur 109 Hold	mber dcroft L	ane			10f. Zip Code 20878			10g. Citizen of What Country?  United States			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ried 2X Married	12. Was Decedent Armed Forces? 1  Yes 2 If Yes, Give Year or Dates.		11	Vas Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto Specify:		14.	Race - Ameri Black, White, cify: Bla	can Indian, etc.	
vithin 72 hou iene. • than "natu the Medical	Completed	(Spe Elementary/Sec 12t		Education grade completed) College (1-4 or	5+)	(Give k life. DC	O NOT use retired)	during most of worki			of Business In	ndustry	
d be filed v Mental Hyg arked othe	To Be	17. Father's Name (	First, Middle, Las chard Me	,		1	1 1	18. Mother's Name	e (First, Middle, N	Maiden Surn	ame)	•	
and 2 shoul fealth and sm 27 is ma her trauma		19a. Informant's Na  Juanita	Melvin/W			109 F	loldcroft	and Number or Rura	•	urg, ]	MD 208	78	
it. Page 1 arthment of hartant: If ite		4 Donation	☐ Cremation 3 5 ☐ Other (Spe	<i>Y</i>	Man Cen	emetery, crem	sition (Name of patory or other place Veterans at Chelf	enham Por	5/2011	Che1	tenham	, MD	
permit Depar Impor any in		21. Signature of Full	KAL	mplication that cause	d the death	55	38 MAr1b	oro Pike,	Forestv	ille,		47	_
Physician/ Medical Examiner		shock, or heal Immediate Cause ( disease or condition resulting in death)	rt failu. List only (Final	a. Response to line as as	e. ator	uen e f):	ilure				(, v, +	Approximate Interval Between Onset and Death	
eate be executed physician and the burial-transit	edical Examiner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or implury that initiated events resulting in death) Last  Large Right Middle Cerubral Arteriary Infant  Due to (or as a consequence of):  C											
To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death.  When Funeral Director. After this certificate has been signed by the attending physis completed filled in by the funeral director, page 2 should be detached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1  Live Birth 4  Pregnant a	2 Feta	ldeath 3 🗌	Ectopic pregnanc Other (specify)	Sy		23d.	. Date of deliv Month	very Day Year	
quires that t en signed b uld be deta		Part II. Other signif		contributing to death to Pentensio			nderlying cause given					he cause of death?	1
The law recate has been page 2 sho	Completed by	Arterial Comestive		bosis, Co Failure,		don you		ease	24a. Was a autops perfor 1 \(\sum \) Yes	med?	4b. Were auto prior to co death? 1 \(\sum \) Yes	opsy findings available ompletion of cause of	
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nding Physath. T. After this e funeral di	icate: To	27. Manner of Death  1 🔀 Natural  2 🗌 Accident	<u> </u>	28a. Date of inju (Month, Da	iry	ER/Outpatient 28b. Time of injury	28c. Injury work	4 □ Nursing Ho y at	me 5 Reside 28d. Describe ho			y)	
tal or Atte is after de al Director led in by th	al Certificate:	3 Suicide 4 Homicide	6 Could not determine	be 290 Blood of Init	ury - At hor c. (Specify)	me, farm, stre	et, factory, office	7	28f. Location (St. City or Town		mber or Rura	l Route Number,	
thin 24 hou the Funer mpleted fill	Medical	(Check 2 only one) 3	☐ Medical Exam	ysician: To the best of miner: On the basis of e arse Practioner: To the	xamination	and/or investi-	gation, in my opinic eath occurred at the	on, death occurred at e time, date and place	the time, date an e, and due to the	d place, and cause(s) and	due to the ca manner as st	use(s) and manner state tated.	ed.
<b>7</b>		29b. Signature and	wpu	9-6M	P	00.1	29c. License	6 number 6450	2	9d. Date sig	ened (Month,	Day, Year)	
6				completed cause of d M.D. 9901	Med	ical Co	nter Dri	ive. Rocks	zille.MD	2085	0		
Stat Registra	_	31. Date filed (Month	n, Day, Year)	32. Registra	ar's signatu	facts	/	, noch			-		

Division of Vital Records, P.O. Box 68760

17:21 HR

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 Physician/ 0434A Faye Benson Nock Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death **Examiner** 4b. City, Town, or Location of Death PAINSULA REGIONAL HICOMICE edical 346186414 ear If Under 24 Hrs 9. Birthplace (State or Foreign Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min (Month, Day, Year) **Director** 214-32-0137 1 □ M 2**X** F 78 05-1-1933 MD Usual Residence of Deced show 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Snow Hill Worcester 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 315 East Market St. P.O. Box 261 21863 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12 should be filed withi lith and Mental Hygiene 27 is marked other the r traumatic event, the Housewife Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Chester W. Benson Irene Penuel Department of Health and Important: If item 27 is m am injury or other training. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Byrd Nock, Jr. Spouse 315 Market St., Snow Hill, MD, 21863 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Salisbury Crematory 12-9-2011 | Salisbury, MD Sign, ture of Fun ral vice Licensee 22. Name and Address of Facility Holloway Funeral Home P.A. CFSP 501 Snow Hill Rd., Salisbury, MD, 21804 23a. Part 1. Enter the disease Do not enter the mode of dying, such as cardiac or respiratory arrest, or complications that caused the death. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on ch line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine consequence of Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death ed by the a detached i Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 1 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No has prior to completion of cause of death? page 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 👿 No Other: 1  $\square$  Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 K Natural 5 Pending work? 1 🔲 Yes М 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State

29b. Signature and title

TRISH

30. Name and address of person who comple

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Registrar DHMH 17 Rev 06-2011 21801

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ause of death (Item 23a) (Type, Print)

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€	Exami	ner	4a. Facility Name (i. <b>Suburba</b> :			ber)		4b. City, To Beth			of Death		4	c. County o		rv	
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036	should be filed within 72 hours after death with the Maryland and Mental Hygiene.  is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	2	11. Marital Status 1 ☐ Never Mari 3 🙀 Widowed	ried 2  Marrie	12. Was Dece Armed For 1 ☐ Yes If Yes, Giv Year or Da	ces? 2X No	1 -	Vas Deceder f Yes, specify			gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)			- Americ , White, Bla		
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Baltimore, Maryland 21215-0036	ld be filed v Mental Hyg arked othe atic event,	To Be	17. Father's Name (		st)						er's Name	(First, Middle,	Maider	n Surname)			
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_	oe execut ician and burial-tra	al E	resulting in death)		Due to (	or as a conse	quence of):										
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Box	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu		IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 5 9 ☐ Unknown	months? No	23c. If yes, outo 1  Live E 4  Pregr 9  Unkn	Birth 2 ☐ Fe ant at time o	etal death 3	Ectopic pre Other (spec		′				23d. Date Mon		ery Day	Year
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ou c	ending eath. rr. After	icate	1 X Natural 2 ☐ Accident	5 Pending Investigat	ion (Monti	n, Day, Year)	injury	M 230.	work?	res 2 🗆		ou. Describe i	iow inju	ry occurred	,		
Division	al or Atte s after de Il Directo	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determine	28e. Place	of Injury - At I g, etc. <i>(</i> S <i>p</i> ec	nome, farm, stre	et, factory, o	ffice		2	8f. Location (S City or Tox			or Rurai	Route Num	ber,
	To the Hospital or Attending Phy within 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral	Medical	(Check 2	Medical Exa	hysician: To the be miner: On the basi urse Practitioner:	s of examinati	on and/or invest	gation, in my	opinion	n, death oc	curred at t	he time, date a	and place	e, and due	to the ca	use(s) and m	anner stated.
	To the Within To the COMM		29b. Signature and	title of certifier						number			29d. Da	ate signed	(Month,	Day, Year)	
	2	-	30 Name and address	ese of nercon wh	o completed equa-	of dooth (le-	m 22c\ (Ti T		272					12/1	3/	2011	
0	R		30. Name and addre Lori G. I					, Beth	esd	a, MI	208	314					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOYCE ANN WILLETT OLIVER DEC 2011 9:20P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4107 BLUEBIRD DRIVE WALDORF CHARLES If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 8. Date of Birth 1 M 2 X F OCT. 15, 1956 MARYLAND 219-72-4062 **Director** 55 Usual Residence of Decedent 28a-f shov 10a. State r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo MD CHARLES LA PLATA 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4107 BLUEBIRD DRIVE 20603 U. S. A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 WNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event \*\*\*. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ASSISTANT MANAGER BANK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) THOMAS GLYNN WILLETT EUNICE ROSE GRAY 19a. Informant's Name/Relationship (Type, Print) SPOUSE-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTHONY L. OLIVER JR. 4107 BLUEBIRD DRIVE WALDORF, MD 20603 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State DECEMBER cemetery, crematory or other place XBurial 2 Cremation 3 Removal from State TRINITY MEM.GRDNS, 28, 2011 4 ☐ Donation 5 ☐ Other (Specify) WALDORF, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of this certificate has autopsy perform death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2-1 No Certificate: To 4 Nursing Home 1 Inpatient 2 I ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 - Pending injury 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation filled in by the within 24 hours after deal To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To this best of my knowledge 29b. Signature and title of certifier 29d. Date signed (Menth, Day, Year) completed cause of death (Item 23a) (Type, Print) 0

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31. Date filed (Month, Day Yea.

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Month GRACE MARIE OLINGER 20,2011 Dec Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Upper Chesapeake Medical Harford Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min. 5/30/1931 PA 215-28-8101 1 M 2 TYP 80 Director Usual Residence of Decedent 10a. State Department of the auth and Mental Hygiene. Importantly, or items 23a or 28a-f sho important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Darlington 1 Tes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Completed by Funeral 1939 Glen Cove Road 21034 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc Armed Forces 1 Never Married 2 X Married 1 Yes 2X No within 72 hours after 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be be filed 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) Gentry Glen Phipps Grace Carr Page 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1939 Glen Cove Road, Darlington, MD 19a. Informant's Name/Relationship (Type, Print) Kermit Olinger/Spouse 21034 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Darlington Cem. 12/23/11 Darlington, MD 21. Signature of Fun A | Service Liven 22. Name and Address of Facility Cover Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the dispuse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on such line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last or as a conse dience of Physician/Medical attending p IF FEMALE. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown Box ( 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) by been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes cate has been signated by page 2 should by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law autopsy performed this certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 100 Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After t 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation Could not be in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatura 29c. License number 29d. Date signed (Month, Day, Year) 30. Name a

State Registrar

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32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 19b per fh g923 1-26-12 vt State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ December 28, 2011 Edna Mary O'Hara 12:40 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Kline Hospice House Mount Airy Frederick Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days March 14, 1 M 2 X F Hours <sup>Year</sup> 1920 214-32-4327 Director 91 Yrs Maryland Usual Residence of Decedent 28a-f show 10b. County 10a. State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 □ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 110 Burgess Hill Way, Apartment 111 United States of America or items within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", If Yes Give White 3 X Widowed 4 Divorced Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 11 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental t. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked or ဂ Charles C. Knill, Sr. Addie Keefer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addres Fireet and Number or Rural Route Number, City or Town, State, Zip Code)

9509 Bravel Hill Road, Woodsboro, Maryland 21798 Peggy B. Crum / Daughter Department of Health Important: If item 2: any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State Mount Olivet Cemetery December 30, Frederick, Maryland 4 Donation 5 Other (Specify Signature of Juneral Service Licen 22. Name and Address of Facility **Keeney and Basford P.A. Funeral Home** M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each live Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a cons aur nce of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence o Exami The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) nding physician a use as the burial Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery atten for us Live Birth 2 Fetal death
Pregnant at time of death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months2 Month Day ed by the a detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown Yes 2 No 9 Unknown P.O. signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an has page 2 autopsy performed? prior to completion of cause of death? certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: ည 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 other (Sp After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pendina 1 Yes 2 No М Accident after death Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined building, etc. (Specify) within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and little of certif 29d. Date signed (Month. Day, Year, M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar . Date filed (Month, Day, Yea . IAN 0 4 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 8 JOSEPH PETERS December 7:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Jannth, Pay Year 1923 078-14-6845 1 🕅 M 2 🗆 F 88 Months |Massachusetts **Director** Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 'item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Funeral Director MD Frederick Frederick 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5699 Crabapple Drive 21701 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian rmed Forces?
X Yes 2 No
1941 ive 1946
ear of Dates. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 XWidowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) US Navy Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ၉ Joseph W. Peters Sr. Jessie Pratt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Tozzolo (Son) 198 Puma Drive, Hanover, PA 17331 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c, Location - City or Town, State Arington Nati. Cem. Jan. 12,20**1**2 Fort Myer, VA 4 Donation 5 ☐ Other (Specify) Signatore of Funeral Service Licensee Keeney & Basford P.A. Funeral Home 106 E. Church St., Frederick, MD 2 MO1612 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pisc Scizure 2- WEKK disease or condition Medical resulting in death) **Examiner** WEEKS on all being costru Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to jor as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit L WREK PHRUMONIA Due to (or as a consequence of) resulting in death) Last Deinerha Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🔀 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 5  $\square$  Pending 1 Natural 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical

15 pm

29a. Certifier (Check

29b. Signature and title of certifier

Five whom MU

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

7 th 5+

32. Registrar's Signat

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

100062975

29d, Date signed (Month, Day, Year)

12/13/11

MD 2170

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42345 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lorraine Elizabeth Polk 5:30 P. December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Cheverly Prince George's Hospital Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Months 83 **Director** 579-40-5196 1 M 2 XF Princess Anne, 04/01/1928 Maryland 28a-f show 10a. State items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director D.C. 1X Yes 2 ☐ No Washington 10e. Street and Number 10g. Citizen of What Country? Funeral 133 36th St., N.E. 20019 permit. Page 1 and 2 should be filed within 72 hours after death "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Completed 3 🗌 Widowed 4 🔀 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ced other than 's event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 11th U.S. Government <u>Secretary/Docket's Clerk</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F 7 is marked o 2 of Health and Menta f item 27 is marked r other traumatic e Beatrice Mason T. White Fenwick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Hitch/ Daughter 6309 District Heights Pkwy.,Dist. Hgts.,Md.20747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 10 T 1 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Mt. Olivet Cem. 12/22/11 Washington, D.C. 21. Signature of Funeral Service Licensee <sup>22</sup>. Name and Address of Facility
Henry S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D. a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ UNG CANCER Medical resulting in death) Due to (or as a consequence of) Examiner CARDIAC MERHYTHMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine as the burial-tran Due to (or as a consequence of) nding physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Day Year 5 Other (specify) signed by the ar Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy 2 🗌 No Yes 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Director: A Investigation 1 Yes 2 No ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of c 29c. License number D 55703 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUSPITAL TSION CHEVERLY

State

Registrar

31. Date filed (Month, NFC 2 1

DEC 2

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are LegIble. State of Maryland / Department of Health and Mental Hygiene

Jam <b>e</b> s	Henry	Peoples	

2011 42346	20	)		4	2	3	L	1
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		Registrar Certificate of Death	R	leg. No.							
Physici		Month Day Year									
Medical Exam	iner	James nemy reopies		r 14, 2011	1259 hrs						
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of I 6717 Valley Park Road Capital Heights	Death	4c. County of I Prince Ge							
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2			9. Birthplace (State or oreign						
Director	ı	578-94-1824 1 M 2 F 43 Yrs. Months Days Hours	Min. July 2	2, 1968	Country) DC						
any		Usual Residence of Decedent  10a. State 10b. County 10c. City. Town or Location			10d. Inside City Limits						
le l	5		ol Heights	5	1 X Yes 2 No						
Maryl 28a-	Je Ct	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What	Country?						
h the 23a or	Ö	6717 Valley Park Road 20743		United	States						
ath wi tems	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Proceedings of the Company of		14. Race - / White, e	American Indian, Black, etc.						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatite event, the Medical Examiner must be negtified at once.	, Fu	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify:	African						
urs af I <b>tural</b> Amin	d by	or Dates:		16b. Kind of Busin	American less/Industry						
72 bo	ete	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT us	e retired)								
o36	Completed	2 Overnight Stock	er	P	rivate						
15-0 illed w Hygid	ပ္ပ	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	Name (First, Middle, I	Maiden Surname)							
121 d be f lental	Be (	James Henry Peoples, Sr.	Josephi	ne Hamlet							
MD 21215-0036 11 should be filed within 7 th and Mental Hygene. 127 is marked other than umatic event, the Medica	To	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number 2015 Charieties J. Lynn									
and 2 fealth tem 2		Rhonda Davis - Wife 2915 Christina Lyn  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		1emple H1							
OFF Best 1 It of 1 It if i		TT	Date Dec. 22, 2011	Landowa	er, Maryland						
Baltimore, permit. Pages I ar Department of Hea Important: If itel injury or other tr		4 Donation 5 Other Specify: Harmony  21. Signature of Fuperal Service Licensee 1 22. Name and Address of Facility of		1							
Dem Dem Inju		21. Signature of Fuperal Service Licensee  7. Stewart 25  4001 Benning Ro									
Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card failure. List only one cause on each line.	liac or respiratory erro	est, shock, or heart	Approximate Interval						
/Medical Examiner		Immediate Cause (Final disease a. Multiple Gunshot Wounds			Between Onset and Death						
_Adminici		or condition resulting in death)  Due to (or as a consequence of):									
	- i	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
_	튑	cause. Enter Underlying Cause (Disease or injury that initiated									
ited J ansit	Examiner	events resulting in death) Last Due to (or as a consequence of): d.			F. 13						
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'60, ate be	₩ W	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	livery						
certific	ian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pr	regnancy	Month	Day Year						
Box 68760 e death certificate b the attending physical ed for use as the bu	Physicia	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown			ì						
ਵੜੇ ਨੂੰ		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	. 23e. Did to	bacco use contribut	te to the cause of death?						
ords, P.O. w requires that the speen signed by should be detach	d b		1 Yes	2 <b>✓</b> No 3	Probably 4 Unknown						
rds requi	e e		24a. Was a		e autopsy findings available						
of Vital Records, og Physician: The law requir Wher this certificate has been si meral director, page 2 should be	Completed		autop: perfor 1 ✓ Yes	med? dea							
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical 26.Place of Death (Ch		2 NO 1 V	Yes 2 No						
Vita ysicia his ce direct	o Be	avamina of		Residence 6 🗸	Other; Scene						
n of ding Ph		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	Cubinatabas	now injury occurred							
ion ttendi teath. tor:	읉	1 Natural 5 Pending FOUND: 1 Yes 2 No No No Notice 1, No	Subject shot	t by law enforce	ement						
Division pital or Attendii ours after death.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S or Town, St		r Rural Route Number, City						
Spital hours neral	3	4 V Homicide determined (Specify) Single Family Home	6717 Valley Pa	ark Road, District							
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one)  2 Medical Exsminer: On the basis of examination and/or investigation, in my opinion, death occurred.									
To with	Mec	and manner stated.  29b. Signature and title of certifier  29c. License number			(Month, Day, Year)						
		O.C.M.E.		December 15							
	}	30. Name and address of person who completed cause of death (Item 23a)		L							
23 1		Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Ba	altimore, MD 212	223							
	ate	31. Date filed (Month, Day Year)  DEC 2 1 2011  Server 8. Registrar Signature 8.									
Regist											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle 1 ast) 2. Date of Death Physician/ Year Month Day 2011 George W. Parsons Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 51156414 KENINSULA REGIONAL MARCOL HICOMICO Year If Under 24 Hrs Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) 35 **Director** 216-90-9897 Usual Residence of Deced 1 **X** M 2 □ F 7-4-1976 MD show 10a. State notified at 10c City Town or Location 10d. Inside City Limits Director 28a-f tX☐ Yes 2 ☐ No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be r Funeral 105 Overlook Dr. Apt 1D 21804 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ō þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Never Worked Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev မ Margaret C. Kohlhoff Herman W. Parsons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Overlook Dr., Salisbury, MD 21804 James Parsons Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 12-12-2011 | Hebron, MD Springhill Memory Gd. 22. Name and Address of Facility Holloway Funeral Home P.A. 21. Signature of Funeral Servi dicenser 0 Rd., Salisbury, MD, 21804 Snow Hill 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph. sician FUNGEMIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examir and Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical The law requires that the death certificate be Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 3 ☐ Ectopic pregna 5 ☐ Other (specify) Month Day Year Pregnant at time of death Unknown the 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Yes 2 No ဂ္ 1 Minpatient 2 ER/Outpatient 3 DOA funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at Certificate: 28d. Describe how injury occurred hours after death.

uneral Director: After the furth of t Vilatural 5 Pending 1 Tyes 2 🗌 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 24

To the F

complet 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State

Registrar

DHMH 17 Rev 06-2011

STREET, SALISBURY, MD 2180

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

KUMAR SINGH, 100E. CARROL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Marylan		rtment of H			giene Reg. No. 20 1		42348
Pi	nysici	an	Decedent's Name (First, Middle, Last     Jewell	Bennett	Pitts	6		2. Date of Dea Month Dec .	6, Day 2011	/ear	3. Time of Death 3:30 a M
	Medic xamin	al	4a. Facility Name (If not institution, give		FICE		Location of Death	Dec.	4c. County o		3.30 a
			Univ. of Mary			em If Under 1 Year	Baltimo		h	O. District	Jan Chat a Camina
	neral ector		5. Social Security Number 6. S- 218-30-2085	ex 7. Age (In yrs. ☐ M 2♥ F 75	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day May 25,	, 1936	Coui	place (State or Foreign ntry) aware
pue	SIII		Usual Residence of Decedent  10a. State 10b. County		y, Town or Loc	eation					10d. Inside City Limits
Maryl	iffed a	tor	MD Dorchest	cer		Lin	ıkwood				1 ☐ Yes 2 📉 No
	the nut	Funeral Director	10e. Street and Number	7:11 D 1		10f. Zip Code	01005		10g. Citizen of Wi		
	must	eral	5321 Beaver Neck V	12. Was Decedent Ever in U	.S. 13. W	Vas Decedent of H	21835 ispanic Origin? (Sp	ecify Yes or No-			can Indian,
d 21215-0036 CCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCC	is manded ontain manded, or many coast or coast show a unatile or and the Medical Examiner must be rutilised at	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 <b>X</b> ☐ No If Yes, Give Year or Dates:		Yes, specify Cuba  ☐ Yes 2 A No	n, Mexican, Puerto Specify:	Rican, etc.)	Specify:	, White, wh	etc. ite
<b>5-0</b>	dical	leted	15, Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced	ent's Usual Occup- kind of work done	ation during most of work f)	ing	16b. Kind of Bus	iness/In	dustry
d withir	The M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	##6. D	line wor			elect	ron	ics
<b>⊆</b> 8 = 3	evant,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam			)	
should nd Mer	matic	은	Ray Bennett  19a. Informant's Name/Relationship (7)	Type, Print)	19b. Mailing	g Address (Street	NETT1e and Number or Rur	Venable Tal Route Number		itate, Zip	Code)
1 and 2 Health a	er trai		Laurence D. Pitts	husband	_		ck Villag			-	
Pages 1	or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	nemoval nom State		sition (Name of latory or other place		Date	20c. Location - C		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene.	any Injury or other traumatic		' 4 □ Donation 5 □ Other (Specif)  21. Signature of Funeral Service Licen		22.	Name and Addres	ss of Facility Tho	omas Fun	East New	ne P	
			23a. Part 1. Enter the disease, or comp	plications that caused the deat			St., Car			013	Approximate
Physi	ician	1	shock, or heart failure. List only Immediate Cause (Final disease or condition	Lung Canc	er						Interval Between Onset and Death
/Med Exan	dical niner		resulting in death)	Due to (or as a conseq							
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8760, ate be ex	the burial-transit	dical Ex		Due to (or as a conseq	uerice or).						
C 68 artificat	e as the	Medi	IF FEMALE:							_	
Hecords, P.O. Box 68/60, The law requires that the death certificate be executed to has been strongly by the attending physician and	tached for use as I	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 XNo 9 □ Unknown	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of degin Unknown	Ideath 3 🗌	Ectopic pregnancy Other <i>(specify)</i>			23d. Date Mon		Pery Day Year
dS, P.	e de	by	Part II. Other significant conditions of	ontributing to death but not res	ulting in the un	derlying cause giv	en in Part I.				the cause of death?
VITAL MECOLDS, sician: The law requires to conflict the base since	2 should l	Completed						24a. Was	an 24b. W	ere aut	opsy findings available ompletion of cause of
	page 2 s	Com						autop perfo 1 🗆 Yes	rmed? de	eath?	2□ No
VITAL P Sician: Th		o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 □ No	Hospital: 1 ☑ Inpatient 2 □	ER/Outpatient	3□ DOA Oth	er: 4 Nursing H		one) dence 6 □Othe	r /Sneci	(h)
On Of ding Phys h. After this	tuneral	$\vdash$	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor			how injury occurre		197
UIVISION Il or Attending after death.	d in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined					28f. Location (S City or Tox	Street and Numbe wn, State)	r or Rui	ral Route Number,
DIVISION Of VITA To the Hospital or Attending Physicien: within 24 hours after death. To the Finand Director, After this certific	letely fille	edical C		ysician: To the best of my kno niner: On the basis of examina and manner stated.							
To th within	comp	Me	29b. Signature and title of certifier	7		29c. Licens			29d. Date signed Dec. 1		
	0/	1	20 Name and address of	nomploted with a state of	03a\ /T		<del>2</del> U				
	S		30. Name and address of person who Dr. Daniel Med:	ina. 22 S. G	reene	St B	altimor	e. Mď '	21201		
	Sta egistr		31. Date filed (Month, Day, Year)	3. Registrar's Signa	ture have	KN					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month GERALD Μ. PUFFINBURGER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western MD Regional Medical Center Cumberland If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 11/27/1941 West Virginia 70 **Director** 232-60-7391 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho idical Examiner must be notified at Director WV Mineral Fort Ashby 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral HC 86, Box 124 26719 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Was Decedon. Armed Forces?

1 ☐ Yes 2 🗶 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry and Mental Hygiene. is marked other than life. DO NOT use retired) Alliant Tech Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Systems it. Page 1 and 2 should be filed wi rtment of Health and Mental Hygis rtant: If item 27 is marked other njury or other traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Norman Puffinburger Wilda McCleary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Puffinburger / Son 337 Dunn Drive, Fort Ashby, WV 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date Fort Ashby Cemetery 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/17/2011 Fort Ashby, WV 4 Donation 5 Other (Specify) 22. Name and Address of Facility Upchurch Funeral P.O. Box 1260, Fort Ashby, WV Signature of Funeral Service Licen Home Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ COPD End StagE Medical resulting in death) Examiner falun Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cardio my of Athe that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death been signed by the should be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed Yes 2 certificate 2 🗌 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at After 1 Natural 5 Pending work? 2 🗌 No 24 hours after death. Funeral Director; A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Danita Packard 12500 Willowbrook ROad, 21502 Cumberland, MD Date filed (Month, Day, Year) 82. Registrar's Signature

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland	d / Department of Health and N Certificate of Death	Mental Hygiene 2011 42350
			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No.  2. Date of Death  3. Time of Death
	Physicia		Roger Price		Month Day Year December 8, 2011 10:40 P.M
	Medio Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	<i>*</i>		Southern Maryland Hospital	Clinton	Prince George's
1	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. la 1 N 2 F 57	ast birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.  Yrs.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Wash.,D.C.
	od at	١	Usual Residence of Decedent  10a, State 10b, County 10c, City	v. Town or Location	10d. Inside City Limits
	anylar ka-fsl ified	Director		Suitland	1 ¥2 Yes 2 □ No
	the M		10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	n with	Funeral	2931 Victory Lane	20746	U.S.A.
	deatl r item iner r		11. Marital Status  12. Was Decedent Ever in U.S Armed Forces?  1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	<ol> <li>Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.
036	s after 'al", o Exam	d by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 🏖 No Specify:	Specify: Black
2-0	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho is the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind of Business/Industry
12	hin 72 ne. than ' ie Me	mo	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO NOT use retired)	
9 9	ed wit Hygie other	Be	12th 17. Father's Name (First, Middle, Last)	Boiler Mechanic	Boiler/Furnace Cleaning (e (First, Middle, Maiden Surname)
lan	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	ပ	James Thomas Price		Mae Anderson
lary	should and N is ma auma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura	
≥,	ind 2 steadth		Arturo Price/ Son	1235 Simms Pl.,N.E. #	
lore	ge 1 a nt of H : If ite or oth		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State ce	emetery, crematory or other place)	Date 20c. Location - City or Town, State
Baltimore, Maryland 21215-0036	nit. Parant artmer ortant injury	l ,	4 ☐ Donation 5 ☐ Other (Specify) Ches  21. Signature of Funeral Service Licensee	sapeake Crematory, Inc. 1	
Ba	permi Depar Impo any ir		Valate MI Jamil	22. Name and Address of Facility Henry S. Washingto	on & Sons Co., Inc.
			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.		A Interval Retween
	Physician/		Immediate Cause (Final disease or condition Methics Win R	Resistant Staphylococcus ac	onset and Death
بر	Medical Examiner		resulting in death)  Due to (or as a consequence)	ence of):	
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence)	pence of):	
	nted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c		
	ate be executed hysician and the burial-transit	EX	resulting in death) Last  Due to (or as a consequence)	ence of):	
9	ate be ohysic the bu	edical	d		
89	eath certifica attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnan		23d. Date of delivery
30X	e atter	Physician/Me	in the past 12 months?  1		Month Day Year
0	t the c by the	Phys	g Unknown g Unknown	III I I I I I I I I I I I I I I I I I	
Division of Vital Records, P.O. Box 68760	requires that the dea been signed by the s should be detached	by	Part II. Other significant conditions contributing to death but not result to the support of the	liting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
ğ	requir been s	letec	Plante Rearl Faiting		24a. Was an 24b. Were autopsy findings available
ပ္ပ	Physician: The law r r this certificate has b aral director, page 2 s	Completed	occur o reserve		autopsy prior to completion of cause of death?
a F	ian: Ti rtifical ctor, p	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check	1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
Ĭ	hysic his ce al dire	은	1 Yes 2 No Hospital: 1 Inpatient 2 E		ome 5 Residence 6 Other (Specify)
100	ding P h. After t funera	ate:	1 ✓ Natural 5 ☐ Pending (Month, Day, Year)	injury work?	28d. Describe how injury occurred
Sio	Attendrated r deat	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hom	me, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number,
<u> </u>	tal or as after al Direction led in l		building, etc. (Specify)		City or Town, State)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		and/or investigation, in my opinion, death occurred at	t the time, date and place, and due to the cause(s) and manner stated.
	fo the vithin 2 ormple	ž	only one) 3 Continuing Nurse Practitioner: To the best of ma 29b. Signature and till an certifier		
	->-0		Nahr vo	20055120	1
9			30. Name and address of person who completed cause of death (Item 2	23a) (Type, Print)	
	Stat	e	1328 31. Date fled (Month, Devry) 21 32. Registrary Signatur	Southern Uvenue SE Sun	fe310 Washington DC 20032
	Registra	ır	31. Date flood (Aonth, Days) 22. Registrary Signature 32. Registrary Signature 32. Registrary Signature 32. Registrary Signature 33. Registrary Si	race	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ernest Tanner Rice, Jr. December 2011 2:30 p<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Braodmore Assisted Living Washington Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 **¥** M 2 □ F Months Hours Mir Yrs. Director 219-20-3106 85 West Virginia Usual Residence of Decedent 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 No MD Washington <u>Hagerstown</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12313 Delwood Avenue 21740 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. "natural", 3 - Widowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maunufacturing Machinist Be traumatic event, permit. Page 1 and 2 should be filed. Department of Health and Mental Important: If item 27 is reany injury or otherone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Tanner Rice, Sr. Hazel Victoria Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dwayn Rice / Son Clear Spring, MD 21722 13923 Fairview Road. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 12/27/2011 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death Unknown 1 Yes 2 L 9 Unknown Yes 2 No the detached P.0. been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 performed? Yes 2 No certificate ospital or Attending Physician: hours after death.
Ineral Director: After this certific npleted filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To ER/Outpatient 3 DOA 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes М 2 🗌 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Gity or Town, State) determined within 24 hours a

To the Funeral C To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and titl

Halm

Registrar

State

tow

e and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

HRA

			Plea	se Type or Pri	nt in Black I	ndelib	le Ink. E	nsure	All Gopie	<b>₹01</b> 5	e, <del>∥.g</del> gible		
			1 - For State Registrar	State of Ma	ype or Print in Black Indelible Ink. Ensure All AMEND PITEM PERFITS Place Indelible Ink. Ensure All State of Maryland / Department of Health and Me Certificate of Death					Reg. No. 2011 4235			
ı	Physici	an/	1. Decedent's Name (First, Middle	,						2. Date of Death			Death
	Medi	cal	Garl Reeder  4a. Facility Name (if not institution,	er Reeder	Month 12								
	Exami	ner	14000 New Acadi	,			er Marl				c. County of Dea rince G		
	Funeral				(In yrs. last birthday)		1 Year If U	Inder 24 Hrs.	8. Date of Bir	th	9. Bir	thplace (State o	r Foreign
	Director		247–38–8061 Usual Residence of Decedent			8 Yrs. Months Days Hours Will. 3-22			3-22-1	Day Year) South Carolin			.ina
	land show dat	호	10a. State 10b. County		10c. City, Town or Lo	cation						10d. Inside Cit	ty Limits
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	ith the 23a or st be r	Funeral Director	10e. Street and Number			10f. Zip Code					itizen of What Co	·	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	inne	14000 New Acadia	12. Was Decedent E	ver in U.S. 13.		774 lent of Hispani	ic Origin? (Sp	ecify Yes or No-		ted Sta		
98		þ	1 Never Married 2 Marr	Armed Forces? 1 ☐ Yes 2 🖾 I If Yes, Give	No.	<ol> <li>Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto</li> <li>Yes 2 No Specify:</li> </ol>			Rican, etc.)		Black, White, etc.		
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Maryland	ould by d Men marke matic		Jimmie Burke	in (Ting Print)					te Reed				
	and 2 sho Health an tem 27 is		19a. Informant's Name/Relationsh Carl Sylvester I Carl Reeder Jr.	Keeder Jr/ S	on 19924	og Addrass Suda	n P1.	"Upper	Mar Teo	ro' 1	<b>1Ď<sup>™</sup>20772</b> D 20706	p Code)	
Baltimore,	of Hee of Hee fitem		20a. Method of Disposition		20b. Place of Dispo	sition (Nam	ne of		Date		ocation - City or		
ţ	Page 1 ment of tant: If it jury or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		Fort Line	coln			20-2011		entwood	, Maryla	and
Ball	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Services Li	consect 1							s Funera		
			26a. Part 1. Enter the disease, or o	complications that caused		the same and the s					n DC 200	017 Approximate	
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	the de by the ached	Physician/Medica	9 Unknown	9 🗌 Unknown									
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ooe	has by a by a by a by a by a by a by a by	Completed							24a. Was autop	psy	prior to	topsy findings a completion of ca	vailable ause of
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Vita	ding Phys h. After this funeral dii	To Be	examiner?	26. Place of Death (Check only one)  Hospital:  1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA  Other: 4 □ Nursing Home 5 ★ Residence 6 □ Other (Specify)									
Division of Vital Records,		Certificate: 1	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury	28b. Time of		c. Injury at work?		28d. Describe h			ary)	
ion			2 Accident Investigation of Could n	ation of he				M 1 Yes 2 No					
ivis	after after Direct		4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
_	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completed filled in by the	Medical	29a. Certifier 1 Certifying	Physician: To the best of m	ny knowledge, death o	occured at the	he time, date a	and place, an	d due to the ca	use(s) ar	nd manner as sta	ated.	
	une n hin 24 the Fu nplete		(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at only one)  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place						e, and due to the cause(s) and manner as stated.			iner stated.	
	7 vit		29b. Signature and title of contifier		29c. License number				29d. Date signed (Month, Day, Year)				
P			D35206  10. Name and address of person who completed cause of death (Item 23a) (Type, Print)						12-20-2011				
R	10		William T. Tan	ner 11701 L	ivingston	Road,	Fort	Washir	ngton MI	0. 2	0744		
	Stat Registra	e ar	31. Date filed (Month, Pay Year)	Census S	Signature	)"							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42353 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 10 Day DEC: 2011 12:31 PM heams ichelle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY OLNEY MONTGOMERY GENERAL HOSPITAL If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** WASH. Days Hours Min 12-15-1966 1 M 2 XF Yrs. DC **Director** 579-04-1522 44 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location must be notified at Director 1 🛣 Yes 2 🗆 No MONTGOMERY SILVER SPRING MD ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 20906 11416 WHISPERING PINES COURT U.S.A. 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 № Never Married 2 ☐ Married 0 Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) 12TH GRADE College (1-4 or 5+) UNEMPLOYED DISABILITY NONE and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ELISE RHEAMS DONALD W. BUTLER permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marks any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **FATHER** DONALD W. BUTLER -3118 - 18TH STREET, N. E. WASHINGTON, DC 20018 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 X Cremation 3 Removal from State 12-17-2011 CLINTON, MD LEE CREMATORY 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PINCKNEY-SPANGLER FUNERAL HOME 524 - 8TH STREET, N. E. WASHINGTON, DC 20002 Inc 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to r as a consequence of): Examiner neumonic Sequentially list conditions, if any, leading to immediate bases. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 1 Yes 2 Month Day Year Pregnant at time of death No Unknown 9 Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Breast Metastali Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv certificate ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 은 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred work? 5 Pending injury 2 🗌 No Investigation Director; / Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) 29a. Certifier 🕍 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the only one) 29c. License number 29d. Date signed (Month, Day, Year) 12-10-2011 D 0057630 Less Squse of death (Item 23a) (Type, Print) who completed 00 32. Registr

DHMH 17 Rev 7/2009

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		nmier, Jr. 1- For State Registrar	State of Man		artment of <i>rtificate of</i>	Health and Death	Mental Hy	_	2 ( ag. No.	011 4235
Physici		1. Decedent's Name (Firs	, ,===,			<u> </u>		2. Date of Deat	th	3. Time of Death
edical Exami	li(e)	Ronald Ri  4a. Facility Name (if not in	ichard Schm		14	b. City, Town, or Lo	ocation of Death	Month December	15, 2011 4c. County of	1348 hrs
		Dorsey Road an		rnamber)	[	Glen Burnie	ocalion of Beatin		Anne Arui	
Funeral		5. Social Security Number	er 6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Bir	th(MM/DD/YYYY)	9. Birthplace (State or
Director		216-80-922	20 1XM 2 1	F 44	Yrs.	Months Days	Hours Min.	April	11, 1967	<sup>Country)</sup> Maryland
<b>b</b>		Usual Residence of Dece 10a. State 10b. 0		140. 03.	T					
ow any			County		, Town or Location					10d. Inside City Limits  1 Yes 2 X No
rylanc a-f sh	향	Maryland Anne Arundel Glen Burnie  10e. Street and Number 10g. Citizen of What Co								
he Ma or 28	Director	no known address							oodinity;	
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Montal Higgene. tean 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	2	11. Marital Status		Decedent Ever in U	.S. 13. Was	n/a. Decedent of Hispa	anic Origin? ( Sp	ecify Yes or No	USA - 14. Race - /	American Indian, Black,
death r iten	uneral	1 Never Married 2	2 Married Armed	d Forces?		s, specify Cuban, I			White, e	
after	by F	3 X Widowed 4	Divorced If Yes, Give	Year	1	Yes 2X No	specify:		Specify:	White
5-0036 led within 72 hours a Hygiene. other than "natural the Medical Examin			on (Specify only highest g			s Usual Occupation st of working life. D			16b. Kind of Busir	ness/Industry
36 in 72 han dical	Completed	Elementary/Secondary	(0-12) College	e (1-4 or 5+)				,		
-00 d with rgiene	ē	12 17. Father's Name (First,	Middle, Last)		meat	cutter	Mother's Name	(First Middle N	food in	dustry
21215-0036 wild be filed within 7 Mental Hygiene. marked other than ic event, the Medical	Be C		Schmier, Sr			"	Dianna		naiden Garname,	
Ould by Men	2	19a. Informant's Name/Re	-	<del></del>	19b. Mailing	Address (Street a			ber, City or Town,	State, Zip Code)
e, MD I and 2 sho Health and item 27 is		Ronald R. S		father	25795	Maple La	ne; Gree	ensboro,	, Marylan	d 21639
Imore, MD 21 Pages 1 and 2 should nent of Health and Me rant: If item 27 is ma or other traumatic ev		20a. Method of Disposition  1 Burial 2 X Cre		20b. I	Place of Disposit crematory or othe	ion (Name of ceme er place) Cn	tery,	Date	20c. Location - C	ity or Town, State
Page nent o		4 Donation 5 0			sapeake	Crematic	n Dec	19 2011	Stevens	ville, Maryla
Baltimore, permit. Pages 1 ar Department of Hee Important: If itelinjury or other tr		21. Signature of Funeral S			22. Na	me and Address o	Facility PO E	Box 160:	Greensb	oro, MD 21639
	_		egle per DV		LTE	egre and	петтепт	ern rui	ieral nom	e, PA
Physician // Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and								
Examiner		Immediate Cause (Final disease or condition resulting in death)  Alcohol and Methadone Intoxication  Due to (or as a consequence of):								
		Sequentially list condition	h	s a consequence of	1).					
	ner	if any, leading to immediate cause. Enter Underlying	ate Due to (or as	s a consequence of	f):					
1.18	Examiner	(Disease or injury that init events resulting in death)	tiated <sup>C.</sup>	s a consequence of	f):					
nd ransit		events resulting in death)	d.		•					
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Box 68760, ne death certificate be earth eatherding physiciane defortuse as the burnance for the burnance for the burnance for the burnance for the burnance for the burnance for the burnance for the formance fo	Me	21 per fh g924 2-2-12 vt  FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date of other persons and the second sec							23d. Date of de	livery
lox 68760 eath certificate attending phys for use as the b	ician/M	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month							Day Year	
BOX deatin	Physic	1 Yes 2 No 9	I Unknown	known	ath 5 J Othe	er (Specify)				
C = 52		Part II. Other significant	conditions contributing	g to death but not re	esulting in the un	derlying cause give	en in Part I.	23e. Did tol	bacco use contribu	te to the cause of death?
tal Records, P.C.  tan: The law requires that certificate has been signed ector, page 2 should be dete	b b							1 Yes	2 No 3	Probably 4 Vulknown
Division of Vital Records rate or Attending Physician: The law requires after death.  al Director: After this certificate has been: led in by the funeral director, page 2 should	Completed							24a. Was a autops		re autopsy findings available r to completion of cause of
ecc he lav ate has	Ĕ	<u> </u>						perfor	med? dea	th?
tal Rec	Be									
Vita	일									Other: Scene
I Of	=	27. Manner of Death	28a. Da (Mor	ite of Injury nth, Day,Year)	28b. Time of Inju	ury 28c. Injury a	at Work? 2	28d. Describe h	ow injury occurred	
ion ftendi leath. for:	[얇	Natural 5 Accident	- ·		unknown	1 Yes	2 <b>X</b> No	unknowi	1	
ivision or Attencather death Director:	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Town, State)								
Spital hours neral	رق	found in wooded area or Town, State Dorsey Rd. & Rt 648								
			ying Physician: To the b al Examiner:On the basis							
To the comp	Medical	29b. Signature and title of	and manner	stated.		29c. License n		ine time, date a		(Month, Day, Year)
		D. III	1/ ^			O.C.M.			December 16	
1		Tunety Try	hall, MD			U.C.IVI.	L.		December 10	., 2011
(1)		30. Name and address of p Pamela E. South	•	ause of death (Item: it <b>Medical</b> Exan	•	N Baltimore 9	Street Baltim	ore MD 21	223	
4										
Sta	ite	31. Date filed (Month Dex		Registrar's Signatur		v. Dailinole C	olieet, Daitiii	1010, 1112 21		

**ORIGINAL** 

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2011 Bobby Smith, Sr. 6:18 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Fort Washington Medical Center Fort Washington If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours 06-28-1946 North Carolina 65 Director 579-56-2236 Usual Residence of Decedent show 10a. State 10d. Inside City Limits 10c. City, Town or Location notified at Director 28a-f 1 Sy Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö er than "natural", or items 23a or the Medical Examiner must be Funeral 2937 Nash Place, SE #1 U.S.A. 20019 be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 至 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: 3 Widowed 4X Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Sec conday (0-12) College (1-4 or 5+) Truck Driver Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ဂ Smith Ella Bell Wall Lester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Randolph Place, NW Washington, DC Margina Smith - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1  $\square$  Burial 2  ${\bf K}$  Cremation 3  $\square$  Removal from State Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Pk Crematory 12-26-11 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald Taylor II Funeral Home Kondel De. 10583 Middleport Lane, White Plains, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final SEPTIL Onset and Death Physician/ Shoc K disease or condition Medical resulting in death) Examiner RESPITTON Esquentially not be difficiled if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examin burial-transi Due to (or as a consequence of) nding physician use as the burial Physician/Medical Accoho! death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ atter in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Year Pregnant at time of death signed by the a Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð PREUMONIA Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No • Hospital or Attending Physician: The law 24 hours after death.
• Funeral Director: After this certificate has I page 2 2 🔀 No 1 T Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 🗌 Yes ည 1 Mnpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work 1 Yes 2 No Investigation 2 Accident
3 Suicide
4 Homicide filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗖 within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat and title of 29c. License number 29d. Date signed (Month, Day, Year) D0026262 151 5011

State Registrar J. Kleiman - 11711 Livingston Road, Fort Washington, Maryland

30. Name and address of persor who completed cause of death (Item 23a) (Type, Print)

32. Registra Signa

Dr. Samuel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 42356 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Thomas William Simpson 20, 2011 1:30 A.M December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Lanham 6715 Longridge Drive Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 577-32-9757 Yrs Washington, DC Director 84 March 1927 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 No Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code ems 23a or ō 10g. Citizen of What Country? Funeral 20706 6715 Longridge Drive IISA er than "natural", or items the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status rmed Forces?

Yes 2 No NAVY Black, White, etc. 1 Never Married 2 Married Ś Maryland 21215-0036 If Yes, Give Year or Dates. 1945-1946 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. other than " life. DO NOT use retired) Elementary/Seconday (0-12) Private College (1-4 or 5+ 12 Contractor Should be filed with and Mental Hygier 7 is marked other to Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Thomas Simpson Grace Emily Blevins traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Lucy E. Simpson / Wife 6715 Longridge Drive, Lanham, MD 20706 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12/22/2011 Mount Olivet Cemetery Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. KHY Right 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ Emphysema disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Que to (or as a doi sequence of, Examin or Attending Physician: The law requires that the death certificate be executed and trar Due to (or as a consequence of): nding physician ar Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year the P.O. ed by t detach signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease, Atherosclerotic Vascular Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Disease, Failure to Thrive, Anemia, Hypothyroidism 24a. Was an page 2 s has autopsy performed? Yes 2 No certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 🗷 Residence 6 Nther (Specify) 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA this s after death. al Director: After the 27. Manner of Death 28a. Date of injury 28c. Injury at 28b. Time of Certificate: (Month, Day, Year) 1 X Natural 5 Pending Accident 1 Tyes 2 🗀 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral D Hospital Medical

To the I within 2 To the I complet

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

(Check

only one) 29b. Signature and title

3

4410 74th Avenue, Landover Hills, MD 20784 Neelam Ashai, M.D., 32. Registra s Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D48213

29d. Date signed (Month, Day, Year,

12/20/2011

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Registrar Amend#20b. PerFHPCC12-28-11cr 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:45p M Shaw Lillies Μ. December 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Co. Suburban Hospital Bethesda Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 XF 09-23-1934 Charlotte, N.C **Director** <u>578-50-2396</u> Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No DC Washington 10e. Street and Number 10f. Zip Code r must be r ō 10g. Citizen of What Country? Funeral 1106 Columbia Road, NW #201 20009 U.S.A. hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. ò 1 Never Married 2 Married by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: Specify: Black 'natural", 3 XWidowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Private</u> Domestic and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dillard Jackson Samuel Marv permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1106 Columbia Road, NW #201 Washington, DC 20009 Adrienne Shaw - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 28, 12<del>-27,</del>11 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility Ronald Taylor II Funeral Home Signature Funeral Service Lice ana 10583 Middleport Lane, White Plains, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Secsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Acute Renal Failure burial-tran Due to (or as a consequence of): Physician/Medical be detached for use as 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ⊟ Fetai ueai ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Metabolic Acidosis, Hyperkalemia 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No Diabetic Ketoacidosis, Acute Hepatic Failure 24a Was an page 2 autopsy performed? Gastrointestinal Bleeding 25. Was case referred to medical or Attending Physician: Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Tes 2 **X**No Certificate: To 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 X Natural 5 - Pending 1 Yes 2 🗌 No Investigation 24 hours after death Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Medumo M.D. December 16, 2011 D17656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tipapurn Woodward 7830 Old Georgetown Rd., #C15 Bethesda, Maryland 20814 32. Registra 's Sigrand State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Helene W. Stephens December 14, 2011 11:55 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Southern Maryland Hospital Prince George's Clinton Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth **Funeral** Age (In yrs. last birthday) Days Hours Min (Month, Day, Year) Director 537-40-5530 1 ☐ M 2**X X**F 85 07/25/1926 Romania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Prince George's Maryland Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2402 Afton USA Street 20748 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Marital Status Black White etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 😿 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Clothing Factory Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Franc 0sterried Maria Constantine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Illinois Stephens Jr. - Husband 2402 Afton Street Temple Hills, Maryland 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat. Cem. 01/03/2012 4 Donation 5 Other (Specify) <u>Arlington, Virginia</u> 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature of Funeral Service Licenses 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a. Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani WEEK disease or condition resulting in death) vocardio Medical r as a consequence of) Examiner terroscler Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant a Day Month Year signed by the at Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Obstructive Palmonary 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Peripheral Arterial 24a. Was an autopsy performe 2 🗌 No 1 🗌 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 🗶 No 26. Place of Death (Check only one) Be Hospital: Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide determined 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier won 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 11701 Livingston Rd ste205 Ft. Washington, MD NO

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 23a, 27, 28a-1, per me, g927 5-11-12 sm

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12 7 201 1 ay 7:50 ам Josephine Rose Schuckle Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico Salisbury 1510-B Sharon Drive Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 1 🗆 M 2 🗶 F 098-14-545 03 | 20 | 1923 New York 88 items 23a or 28a-f show ier must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Salisbury Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21804 USA 1510-B Sharon Drive Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. ral", or iter 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give "natural". 3 🛮 Widowed 4 🗆 Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. alth and Mental Hygiene. 27 is marked other than r traumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Gertrude Frederica James John King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 118 Shamrock Drive, Salisbury, Maryland 21804 Jodie DiPaola daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12 08 2011 Salisbury, Maryland Salisbury Crematory ligna Politoway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) 0 Examiner 2 m Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): burial-tran and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Year Pregnant at time of death be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 \sum Yes should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Aesidence 6 Other (Specify, 2 No ည 1 Inpatient 2 Inpatient 3 Inpa funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes Investigation completely filled in by the 0600 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Support of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only o 29b. Sic nature and title 29d. Date signed (Month, Day, Year) 150497 30. Name and address of cerson who completed cause of death (Item 23a) (Type, Print) WECKMON St. 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEITZ DEC 2011 SR, THOMAS EDWIN 10:43 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 ፟፟፟፝ M 2 □ F Days DEConth, Day, Months 89 <sup>Y</sup>1<sup>a</sup>922 MARYLAND Director 217-18-1080 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director WORCESTER BISHOPVILLE 1 Yes 2 No MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 21813 11622 ST. MARTINS NECK ROAD 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ŏ þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural" Completed 3 Widowed 4 Divorced Specify: WHITE Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene, I other than " Elementary/Seconday (0-12) College (1-4 or 5+) MUNICIPAL UTILITIES CABLE SPLICER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o မ ETHEL V. CALLAHAN SEITZ PLEASANT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 11622 ST. MARTINS NECK ROAD, BISHOPVILLE, MD 21813 CAROLYN R. SEITZ/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) CREMATORY OF DELMARVA 12/7/11 DELMAR, DELAWARE Donation 5 Other (Specify) 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease, or complications trate used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Interval Between Onset and Death Immediate Cause (Final Physician/ MYOCO disease or condition Medical resulting in death) Due to (or as a consequance of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Directo for as a consection of of Exami Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte I be detached for Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 No Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 E Certifing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12/6/11 PS3612 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IM 9733 Healthra for Berlin MD 21811 Baier MD

Registrar
DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/  $20^{12}$ 9:46 A M Ernest C Slonaker Medical c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frost burg WMHS Frostburg Nursing & Rehab Center 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** (Month, Day, Yea Maryland 1**X** M 2 □ F Hours Min. Director 212-38-6533 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location must be notified at Director 1 Yes 2 No Allegany Cumberland MD 10g. Citizen of What Country?
U.S.A. 10e. Street and Numbe 10f. Zip Code ō 21502 Funeral 23a 1 Baltimore Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner Black, White, etc þ 1 Never Married 2 Married 1 X Yes 2 No 1958 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Noivorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, and Mental Hygiene. Elementary/Seconday (0-12) Goodyear Tire & Rubber Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Helen (Porter) Slonaker Fresh Ernest Carroll Slonaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 83 Victoria Lane, Frostburg, MD of Health P.O.A. Edna Glass 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Green Mount Cemetery Dec 14 2011 Cumberland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hafer Funeral Service, P.A. Signature of Funeral Service Licenses 1302 National Hwy., LaVale, MD 23a. Carl 1. Enter the disease, or compiliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Klunding ton Physician/ chorea lens disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last ng physician ar as the burial-t Completed by Physician/Medical Box 68760 IF FEMALE nse 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year been signed by the should be detached 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b autopsy performed 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 7 No 4 Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No M Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mass 21532 MD, 4 S. Broadway, Frostburg, MD Jesus Tan, Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0607 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Mandrin Chesapeake Hospice House Anne Arundel Harwood Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign 1 □ M 2 🕅 F Months Days Hours Min. 12-12-1934 Director Marvland 220-30-8610 Usual Residence of Decedent or 28a-f show notified at 10b. County **Funeral Director** 10c. City. Town or Location 10d. Inside City Limits 1 🗌 Yes 2 💢 No FL. Pasco Zephyrhills 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe 23a items 23a ner must b 35047 McCulloughs Leap 33541 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 🗓 No by o. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 K No Specify: "natural", 3 
▼ Widowed 4 □ Divorced Completed Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other the homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wanona Kathryn Witchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health a item 27 i <u>Kelly L. Swanson, daughter</u> 657 Alder Place, Rose Haven, North Beach, MD 20714 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, mportant: If ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 12-15-11 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. llionhan M00715 8325 Mt. Harmony Lane, Owings, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** amoxi Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical death certificate be 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant Box ( 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 1 🗌 Yes Yes Division of Vital director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\bowtie$  Other (Specify)  $\bowtie$  4  $\bowtie$  DRI  $\bowtie$ 2 A No 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred HOUSE 5 Pending Natural Accident
Suicide 24 hours after death Funeral Director: A 1 🗌 Yes 2 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

32. Registra Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 4:06 P M 2011 Josiane Therese Serra Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Ceci1 E1kton Melbourne Blvd Birthplace (State or Foreign Country) If Under If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 2/17/1954 Months Hours 1 □ M 2**X**XF Director France 214-74-1441 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🔀 No MD Ceci1 E1kton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral USA 21921 423 Melbourne Blvd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11. Marital Status Black, White, etc. 2 🔀 No ğ 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Building Supplies Entrepreneur Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even any injury or other traumatic even Denise M. Peltier Jean Dominique Serra 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 423 Melbourne Blvd. Elkton, MD 21921 Andrew Prettyman - son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 12/18/2011 4 Donation 5 Other (Specify, Rising Sun. MD Foard Funeral Home. PA Signature of Funeral Serus 22. Name and Address of Facility R.T. Foard Funeral Home, PA Queen Street, Rising Sun, MD 21911 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or flear failure. List only one cause, in each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and deedeched for use as the burial-transity that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate has page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To s after deam.

al Director: After the standard in by the funere 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury Natural Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29d. Date 29b. Signature and title ss of person who completed cause of death (Item 23a) (Type, Print) ARI 31. Date filed (Month, Day, 32. Redistrar's Signature State

Registrar

Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

		Please Type or Pl				-	_				
		1 - State of N		epartment of F Certificate of L		/lental Hygle Reg.	201	1 4236			
Physicia	ın/	1. Decedent's Name (First, Middle, Last) William P.	Stewart			2. Date of Death Month	Day Year	3. Time of Death  1 5:05 a <sup>M</sup>			
Medic Examin		4a. Facility Name (if not institution, give street and number,		4b. City, Town, or	r Location of Death	December	ember 14, 2011 5:05  4c. County of Death				
		26 Race Street  5. Social Security Number 6. Sex 7. A			Deposit	Cecil					
Funeral Director		5. Social Security Number 220-18-7790 6. Sex 1 X M 2 F 7. A	Age (In yrs. last birthd 85 Yr	Months Days	8. Date of Birth  7 (Month, Day Yea Feb 20,	year) 926   9. Birthplace (State or Foreign Country)   Maryland					
23a or 28a-f show ist be notified at	tor	10a. State 10b. County	10c. City, Town o					10d. Inside City Limits			
	Director	Maryland Cecil  10e. Street and Number		Port De	posit	100	Citizen of Milest Co	1 X Yes 2 No			
	Funeral	26 Race Street		Tor. Zip Gode	10g	0g. Citizen of What Country? U.S.A.					
items ner mi		11. Marital Status 12. Was Deceden Armed Forces	at Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit				
ıral", or Exami	ed by	1 Never Married 2 Married 1 N Yes 2 If Yes, Give Year or Dates.	□ No	1 ☐ Yes 2 🛣 No				Lack			
Department of Health and Mental Hygiene. Important: If item 273a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed)	(0	ecedent's Usual Occup Give kind of work done o			o. Kind of Business	Industry roving Ground			
		Elementary/Seconday (0-12) College (1-4 o Eleven Years	( D+1	fe. DO NOT use retired) Eavy Equipm	erdeen, 1	_					
	To Be	17. Father's Name (First, Middle, Last)	•		18. Mother's Nam	e (First, Middle, Maid	len Surname)				
d Men marke matic	-	Joseph Stewart  19a. Informant's Name/Relationship (Type, Print)				Margaret J					
nent of Health and int: If item 27 is and or other traus		Michelle Harris (daughte	`				Route Number, City or Town, State, Zip Code)				
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	te cemetery,	Disposition (Name of crematory or other place ar Cemetery	ce)		c. Location - City or				
Departr Importa any inju		21. Signature of Funeral Service Licensee	50	22. Name and Addres	tterson &	Son Fune:	ral Home,	P.A.			
	Н	23a. Part 1. Enter the disease, or complications that caus			ryville, g, such as cardiac		21903-07	Approximate			
/sician/		shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition	ine.	CHO LANGI	o cancia	MA		Interval Between Onset and Death			
Medical aminer		Immediate Cause (Final disease or condition resulting in death)  a.   MEPASTATIC CHO CANCINO MA  Due to (or as a consequence of):									
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):									
nd transit	Examiner	Cause Disease or injury that initiated events  C.  Due to (or as a consequence of):									
sician a burial-	a	resulting in death) Last Due to (or a	is a consequence of):								
ing phy e as the	/Med	IF FEMALE:									
when the former beau.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	23b. Was decedent pregnant in the past 12 months?  1	23d. Date of delivery Month Day Year								
ined by e deta	by P	Part II. Other significant conditions contributing to death	_		ven in Part I.	23e. Did tobaco	co use contribute to	the cause of death?			
een sig	ted	HYPERTENSION, COPD,	DYSUF	DEMIA		1 \( \text{Yes}	2 No 3 □ P	Probably 4 Unknown			
has b	Completed	1				24a. Was an autopsy performed	prior to	rtopsy findings available completion of cause of			
tificate or, pag	Be Co	25. Was case referred to medical		26 PI	ace of Death (Chec	1 Yes 2		s 2 No			
his cer direct	To B		atient 2 ER/Outp	atient 3 DOA Othe	or.	ome 5 Residence	e 6 Other (Spec	cify)			
or. After tl	Certificate:	27. Manner of Death  1 Montatural 5 Pending (Month, D  2 Accident Investigation 3 Suicide 6 Could not be		iry work		28d. Describe how in	njury occurred				
al Direct		4 Demisids determined 28e. Place of It	njury - At home, farm etc. <i>(Specify)</i>	, street, factory, office		28f. Location (Street City or Town, St		ral Route Number,			
he Funer	Medical	29a. Certifier 1 Certifying Physician: To the best of Check 2 Medical Examiner: On the basis of Only one) 3 Certifying Nurse Practioner: To the Check only one of Certifying Nurse Practioner: To the Check of Che	f examination and/or in	nvestigation, in my opinio	on, death occurred a	t the time, date and pl	ace, and due to the	cause(s) and manner stated			
To t		29b. Signature and title of certifier	<u> </u>	29c. License	e number	29d.	Date signed (Monta	h, Day, Year)			
		30. Name and address of person who completed cause of	death (Item 23a) (Tire	ne Print)	5344	12	16/201	/			
VA		30. Name and address of person who completed cause of SURESH DHAW JAWI MD 31. Date filed (Month, Day, Year)  32. Register 1.9. 2011	622 Sil	INION AVE	HAYRE	DEGRACA	EMDZ	1078			
Stat Registra		31. Date filed (Month, Day, Year) 32. Regis	tra s Signature	9. backer	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 42365 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ SRACE 03:15 2 Medical 4a. Facility Name (if not institution, give street and number. 4b. City, Town, or Location of Death 4c. County of Death Examiner Mandrin In-Patient Care Center nne-Arundel <u>Harwooo</u> 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year Social Security Number If Under 24 Hrs. Funeral 1 □ M 2🗓 Days Min 08/29/1932 Director 577-44-5230 Wash D.C Usual Residence of Decedent 28a-f show 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d Inside City Limits Director 1 Yes 2 □ No D.C. Washington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4241 Meade St., N.E. 20019 U.S.A. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Black "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Greening of Work of Course religed)
Currency Examiner
Bureau of Engraving & Printing than Elementary/Seconday (0-12) College (1-4 or 5+) the 12th U.S. Government and Mental Hygie is marked other event, Be be filed \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Department of Health and Ments Important: If item 27 is more any injury or a feet and injury or a feet any injury or a feet and injury or a feet any injury or a feet any injury or a feet any injury or a feet and injury George K. Smith Gladys Marie Coram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vanessa C. Byers/Daughter 4241 Meade St., N.E., Washington, D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cem. 12/17/11 Brentwood, Maryland Signature of Funeral Service Licens Henry S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ STOMACH disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury and that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) attending physician for use as the burial Physician/Medical requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 \( \sum \) Yes 2 \( \sum \) No Month Year Day Pregnant at time of death 5 Other (specify) signed by the a g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 thinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law page 2 s has autopsy performed this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) MANDRIN 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending injury 1 Natural work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: After the function of the functin Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier pleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registr

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31. Date filed (Month, Day, Year)
DEC 1 6 2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Susan Thomaso	on	1- For State Registrar	State of Marylar	nd / Dep	artmen ertificate	t of Health a of Death	and Men	tal Hygien	е	20	1 423	
Physicia Medical Exami	an/ ner	1. Decedent's Name (First, Mid	dle,Last) rie Thomason						Reg. Nof Death h Davember 20		3. Time of Death 0009 hrs	
		4a. Facility Name (if not institut Península Regional I		ber)		4b. City, Town, Salisbury		of Death	Death 4c. County of Death Wicomico			
Funeral Director		5. Social Security Number 214-70-6126	6. Sex 7.	. Age (In yrs.	last birthda		ear If Unde	Min	e of Birth <sub>(M</sub>	M/DD/YYYY) 9. E	Birthplace (State or eign Country)Maryland	
w any		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or L				14/12		10d. Inside City Limits	
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	oline		Dent	On 10f. Zip Code			10g. C	itizen of What Co	1 Yes 2 No	
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36 thin 72 hou te. than "nat	Completed	Elementary/Secondary (0-12)	College (1-4		durin	dent's Usual Occup g most of working lif inesswoma	t or working life. DO NOT use retired)				:/Industry	
21215-0036 ould be filed within 7 Mental Hygiene. a marked other than ie event, the Motita	Be Co	17. Father's Name (First, Middle, Robert Lee Scl			Dus		18.Mother's	Name (First, Mic	ddle, Maider	Recyclin	g	
e, MD 21215-0036  I and 2 should be filed within 7.  Health and Mental Hygiene.  item 27 is marked other than renamatic event, the Melitan	의	19a. Informant's Name/Relations Ronald Thomason	hip (Type, Print)		19b. Ma	iling Address (Stre 6 Laure1	et and Numb	Jane Ke Per or Rural Route Rd. D	e Number, (	City or Town, Stat	e, Zip Code)	
nore, ages l an ont of Hea nt: If iten									20c.	Location - City o	r Town, State	
Baltir permit. I Departme Importarinjary or	Pauch March 12 South Sound St									Dover, Dal Home,	P.A.	
Physician /Medical Examiner	- İ	23a. Part I. Enter the disease, or failure. List only one cause mmediate Cause (Final disease	complications that cause		DO HOL BILLE	ir the mode of dying	, such as can	diac or respirator	y arrest, sh	ock, or heart	21629 Approximate Interval Between Onset and Death	
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Box 68760, he death certificate be executed y the attending physician and hed for use as the burial - transit	IF FEMALE: 23c. If yes, outcome of pregnancy   1								230	d. Date of delivery	y Day Year	
P.O. Box so that the death or gned by the attent or detached for us.		Yes 2 No 9 V Unkr	own 9 Unknown		2 □ (	Other (Specify)	iven in Part I	23e D	id tobacco i	Use contribute to	the cause of death?	
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Physician Physician r this cert al directo		examiner?  1 Yes 2 No	Hospital: 1 / Inpatie	ent 2 E	R/Outpatier		Othor -	eck only one) ursing Home 5	Resider	nce 6 Other		
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To the Host within 24 ho To the Func completely fi	29 (C on	a. Certifier 1 Certifying Physics only	sician: To the best of moner: On the basis of examiner stated.	n: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
/ × × ×	29	Signature and title of certifier	W /n~	- Ref		29c. License O.C.M	number		29d. Date signed (Month, Day, Year)  December 20, 2011			
30. Name and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223												
State Registrar		Date filed (Mooth Day (Yest)	32 Registra					,				

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Examin		4a. Facility Name (if	_		4b. City	_	ocation of Death		4c. County of Death					
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erdea orite miner	by Fi	<ul><li>11. Marital Status</li><li>1 Never Marr</li></ul>	ver Married 2 Married Armed Forces?			1			oanic Origin? (Sp Mexican, Puerto	Rican, etc.)		14. Race - Ar Black, Wi	nite, et	o.
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filed tal Hy ed oth event	To Be	17. Father's Name (	(First, Middle, Last)					1	8. Mother's Nar	ame (First, Middle, Maiden Surname				
ould be d Men marke	-	Edwin	ame/Relationship (7	Time Print		Adkins			Albert		01	- Town Ctata		kins
12 sho alth an 27 is r trau				y – Daugh	iter				d Number or Ru ve, Lak					ge)
of Hee		20a. Method of Disp	position	Removal from State	20b. I	Place of Dispo	sition (Na	me of		Date		_ocation - City		n, State
: Page tment tant: I jury o		4 Donation	5 Other (Speci	fy)					i	-6-2011	Pi	ttsvill	е,	Maryland
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	neral Service Liceri	see Bl	lako			nd Address		Bounds				1 0100/
				no cations that cause								y, Mary	T ,	nd 21804 Approximate
Physician/		Immediate Cause ( disease or condition	(Final	ne cause on each li	ne. Nes	eella	m,	1.						nterval Between Onset and Death
Medical Examiner		resulting in death)		a. Due to (ot/a	s a conseq			Gell	Mil.	L Prut	٦,			
	er	Sequentially list co	onditions,	b. Due to (or a	S a conseq	1000	m	1 00	(000)		,		+	···
nted d ansit	Examiner	cause. Enter Unde Cause (Disease or	erlying injury	200 10 (0) 0	o a conceq	derice 01).								
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requires that the death certificate be been signed by the attending physici should be detached for use as the bi	Physician/Medical	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcom								23d. Date of	deliver	V
death e atte	sicia	in the past 12 1 Yes 2	months?	1 Live Birth	at time of		Ectopic   Other (s	pregnancy pecify)				Month		yay Year
at the of by the etache		9 Unknown		9 Unknown  conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use c								use contribute	to the	cause of death?
ires th signer	d by			LAD,		g		g						ably 4 🗆 Unknown
v requi	lete	0	定,							24a. Was		24b. Were	autops	y findings available
The lay ste has bage 2	Completed	88	M.				-			per	opsy formed?	death	?	pletion of cause of
cian: ertifica	Be	25. Was case referre	red to medical	Hospital:/					e of Death (Che					
Physic this c	<u>۱</u>	1 Yes 2	h No	1 Inpa		ER/Outpatier		Other: 28c. Injury a	-	lome 5 Res			ecify)	
nding ath. :: After e fune	icate	Natural 2 Accident	5 Pending Investigatio	(Month, E	ay, Year)	injury	М	work?	es 2 🗆 No	Zou. Describe	now mjo	iry occurred		
r Atter ter dea rector	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Ir	njury - At he		eet, factor	y, office		28f. Location City or To		nd Number or	Rural F	oute Number,
pital o		00 0 00						-4 H 1'	data and Japan				-1-1-	
To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	Medical	29a. Certifier decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mann (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mann only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mann due to the cause(s) and mann only one) and the time, date and place, and due to the cause(s) and mann only one) and the time, date and place, and due to the cause(s) and mann only one) and the time, date and place, and due to the cause(s) and mann only one) and the time, date and place, and due to the cause(s) and mann only one of the time, date and place, and due to the cause(s) and mann only one of the time, date and place, and due to the cause(s) and mann only one of the time, date and place, and due to the cause(s) and mann only one of the time, date and place, and due to the cause(s) and mann only one of the time, date and place, and due to the cause(s) and mann only one of the time, date and place, and due to the cause(s) and mann only one of the time, date and place, and due to the cause(s) and mann only one of the time, date and place, and due to the cause(s) and mann only one of the time, date and place, and due to the cause(s) and mann only one of the time, date and place, and due to the cause(s) and mann only one of the time, date and place, and the time, date and place, and the time, date and place and the time, date and place and the time, date and place and the time, date and place and the time, date and place and the time, date and place and the time, date and place and the time, date and place and the time, date and place and the time, date and place and the time, date and place and the time, date and the time, date and place and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and									e, and due to the	ne caus	e(s) and manner stated	
To the comp	2	29b. Signature and	title of certifier O				29	c. License r	number		29d. D	ate signed (Mo	nth. Da	av. Year)
		•	Mati					250-	360		12	293/11.		
LITC		H.R.	HEDA	. ,	C .	n 23a) (Type, F	Print)	C+01	RR D	n's	31	LISB	· (5 \$	y.m.)
Stat Registra	e ir	31. Date filed (Mont	DEC 052	32. Rgis	trar's Signa	iture	Sant							

DHMH 17 Rev 06-2011

## Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		. For	State of			artment of F			_	•		
	_	State Registrar			Cer	tificate of E	Death	Re	eg. No. 20	1. 42368		
Physiciar	1/	Decedent's Name (First, Middle,	Last)					2. Date of Death Month	Day Year	3. Time of Death		
Medica Examine		4a. Facility Name (if not institution,	give street and numbe	THO	MAS	4b. City, Town, or	Location of Death	DECEMBER	11 2011 4c. County of Dear	1:39 P M _		
Admini			MEMORIAL 1	HOSPIT	AL	FREDEI	RICK		FREDE			
Funeral Director		5. Social Security Number 218-80-1074	6. Sex 7.	Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, March 2	9. Bir (Co	thplace (State or Foreign Juntry) laryland		
*		Usual Residence of Decedent	1112					March 2	0,1901 F.			
ryland I-f show ied at	<b>Funeral Director</b>	10a. State 10b. County		10c. City	y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ♣ No		
he Ma or 28a e notif		Maryland Free  10e. Street and Number	derick			10f. Zip Code	lerick	1	0g. Citizen of What Co			
s 23a s ust be	era	4604-A	Tuscarora 1	Road			21709		US	SA		
r item	Ē	11. Marital Status 1 ☐ Never Married 2 ♣ Marri	12. Was Decede Armed Force	s?	S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit			
rs after rral", o Exam	ed by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	1 ☐ Yes 2 █ No If Yes, Give Year or Dates.			Specify:		Specify: Wh	nite		
72 hou "natu edical	Completed	15. Deceden (Specify only highes	t's Education st grade completed)		[ (Give	dent's Usual Occup kind of work done o	ation during most of work	king	16b. Kind of Business	Industry		
vithin 7 iene.		Elementary/Seconday (0-12)	College (1-4	or 5+)	life. D	O NOT use retired)  Contrac	rtor		Const	ruction		
		17. Father's Name (First, Middle, La	ast)					ne (First, Middle, M				
d Menida be marke	욘	Gene E. Thomas  19a. Informant's Name/Relationsh	in Cima Driati					Louise M				
12 sho alth and 27 is i		Raymond W. Thomas			1	-			City or Town, State, Zi	p Code)		
of Hear of Hear if item		20a. Method of Disposition  1 Burial 2 Cremation		20b. F	Place of Dispo	sition (Name of	1		20c. Location - City or	r Town, State		
t. Page tment tant: I jury o		4 Donation 5 Other (Sp	pecify)	Вар		natory or other place antown hurch Cer				n, Maryland		
permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		21. Signature of Funeral Service Li	6-Lauler	Name and Address Noleswort 26401 Rids	ss of Facility n-Willian ge Road,	ns, P.A., Damascus	Funeral H , MD 20872	lome 2				
		2 Part 1. Enter the disease, or a shock, or heart failure. List or						or respiratory arres	st,	Approximate Interval Between		
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	5	eptic	ated B	ick			Snset and Death		
Examiner				Days								
D =	Examiner	Esquentiurly list est differential description of the cause. Enter Underlying Cause. (Disease or injury)										
s be executed sician and burial-transit	Exau	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):							
be ey	g		d									
rtificati ling ph	Physician/Med	IF FEMALE:	One House sudes	of nysana								
attenc I for us	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome 1 Live Bir 4 Pregnar		al death 3	Ectopic pregnand Other (specify)	у		23d. Date of de Month	elivery Day Year		
t the de by the tachec	Phys	9 Unknown										
s ths	ੇ ੬	Part II. Other significant condition	is contributing to deat	th but not res	sulting in the L	inderlying cause giv	en in Part I.		acco use contribute to	o the cause of death?  Probably 4 🗆 Unknown		
v requi	Completed							24a. Was ar	24b. Were au	utopsy findings available		
The lav	Ĕ							autops perform 1 \sum Yes 2	ned? death?	completion of cause of		
clan:	Be	25. Was case referred to medical examiner?	Hospital:			26. Pl	ace of Death (Chec					
Physical direction	은	1 Yes 2 No 27. Manner of Death	1 Alng 28a. Date of	injury	ER/Outpatien 28b. Time of	nt 3 🗆 DOA	4 ☐ Nursing H	ome 5 Reside	nce 6 Other (Spe- w injury occurred	cify)		
anding sath. or: Afte	licat	1 Natural 5 Pending 2 Accident Investig	ation	Day, Year)	injury	M 1 🗆	? Yes 2 🗆 No					
or Atta	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	28e. Place of	Injury - At ho etc. (Specify		eet, factory, office		28f. Location (Str City or Town	reet and Number or Ro , State)	ural Route Number,		
ospital hours uneral d filled	Medical	29a. Certifier 1 Certifying	Physician: To the best	t of my know	ledge, death	occured at the time	, date and place, a	nd due to the caus	se(s) and manner as st	tated.		
the He thin 24 the Fu	¥ĕ											
5 ≥ 5 00		29b. Signature and title of certifier	cM sai			29c. License		2	9d. Date signed (Mon	ur, Day, rear)		
0		30. Name and address of person w	vho completed cause of	of death (Item	1 23a) (Type, F	Print)	40 ·	2	7 11			
		1475 Ta No 31. Date filed (Month, Day, Year)	y Ave	Fre	ederia	V V	NO '	21702				
State Registra		DEC 13	2011	strar's Signa	B. 1	rand V						

FRANK G. TRINKA 12/10/11 2:00 PM

				Plea	ise Type or						•	•	gible.		
			For State		State	of Maryland	,	artment of F rtificate of L		and Me	,	2		42369	
			Registrar  1. Decedent's Name	e (First, Middle	, Last)		Cei	tilicate of L	Jealii	2	. Date of De	Reg. No.	011	3. Time of Death	
	Physicia Medic		FRANK	GEOR	GE TRINK	KA, JR.			DEC. 1					2:00P M	
	Examir	ner	4a. Facility Name (if SUBURBA)		_	mber)		4b. City, Town, or BETHES		f Death	4c. County of MONT			of Death CGOMERY	
1	Funeral Director		5. Social Security No. 148-16-		6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. la. 85		If Under 1 Year Months Days	If Under 2 Hours	Min.	. Date of Bird (Month, Da	y, Year)	9. Birth	place (State or Foreign try)	
			Usual Residence o	of Decedent	TEM 2UF		Yrs.				09/22	/1926	NY		
	aryland a-f sh ified at	Director	10a. State MD	10b. County	GOMERY		, Town or Lo HESD <i>E</i>						1	0d. Inside City Limits  1 ☑ Yes 2 ☐ No	
	the M a or 28 se noti		10e. Street and Nun		JOHERI	DE1.	HESDF	10f. Zip Code			Т	10g. Citizen of	What Cour		
	th with ms 23a must b	Funeral	8305 WE	STMON				2081					USA		
920	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If filem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		ied 1 4 Yes If Yes, Gir	edent Ever in U.S. prces? 2 No 19 ve ates. 1945	11	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ın, Mexican,	in? (Specif , Puerto Ric	y Yes or No- an, etc.)		ce - Americ ck, White, WHI	etc.	
15-0	"natu "natu edical	Completed	(Spe		nt's Education st grade completed	T	16a. Decedent's Usual Occupation (Give kind of work done during most of work					16b. Kind of E	iusiness/In	dustry	
212	vithin 7 jiene. er than the M		Elementary/Seco	ndary (0-12)	College (1	-4 or 5+)	FOR E	O NOT use retired) EIGN SER	VICE	OFF	ICER	STATE	DEP	ARTMENT	
and	d be filed v Vental Hyg arked othe atic event,	To Be	17. Father's Name (First, Middle, Last) FRANK GEORGE TRINKA, SR. MAI								irst, Middle,	Maiden Surnan	e)		
Mar	2 should th and Me 27 is mar) traumati	S	19a. Informant's Na			OHER		ng Address (Street							
d)	1 and of Heal item 2		SUSANNE 20a. Method of Disp	oșftion		20b. Pl	ace of Dispo	S WESTMO	- 1		72011				
Baltimore,	Page ment c tant: If jury or		1 ☐ Burial 2 b 4 ☐ Donation	Cremation 5 Other (S	3 ☐ Removal from pecify)	State STA		natory or other place R CREMAT	ORY	2/16	/2011	FREDE	RICK	, MD	
Balt	permit. Page 1 a Department of B Important: If ite any injury or ot once.		21. Signature of Furneral Stylice Licensee  22. Name and Address of Facility P.O. BOY HILTON FUNERAL HOME BARNESVI												
				t failure. List o	complications that nly one cause on ea		. Do not ente	er the mode of dyin	g, such as c	ardiac or re				Approximate Interval Between Onset and Death	
	Medical		Immediate Cause (I disease or condition resulting in death)	n		ORAL /		ETAL HE	MORRI	HAGE		TRAUMA ROKE)	TIC	Onset and Death	
	Examiner	er	Sequentially list cor if any, leading to im	nditions,	b. — Due to	(or as a conseque	ence off:					TOTAL 7	-		
1	executed an and irial-transit	Examiner	cause. Enter Under Cause (Disease or i that initiated events	lying njury	с										
		calE	resulting in death) L	ast	Due to	(or as a conseque	ence of):								
876	incare ng phy as the	Medi	IF FEMALE:												
. Box 68760	to use repopulation Attendanty Privisicans. The law requires triat the death certificate be within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burn		23b. Was decedent in the past 12 n 1 Yes 2 9 Unknown	nonths?	1 Live	nant at time of de	death 3 [	Ectopic pregnance Other (specify)			23d. Da	ery Day Year			
. P.O.	es triat the dea signed by the a I be detached f	by Pr	Part II. Other signifi		-	leath but not resu	lting in the ι	ınderlying cause giv	en in Part I.		l .	,		ne cause of death?	
ords	been signal	leted	ATRIAL MULTIPLE							_	24a. Was			bably 4 Unknown  psy findings available	
Division of Vital Records,	visician: the taw his certificate has b I director, page 2 s	Completed by									autor perfo	osy ormed?/	prior to co death? 1  Yes	mpletion of cause of	
tal	certific rector,	Be	25. Was case referre examiner?		Hospital:	/ _		Othe	ace of Death	n (Check or					
of V	ding Fnys th. After this funeral di	e: <u>1</u> 0	1 Yes 2 2 27. Manner of Death		28a. Date		28b. Time of	28c. Injury	4 ∐ Nur ⁄at			dence 6 Oth		)	
noi	death. stor: Aft	Certificate:	1	5 ☐ Pendin Investig 6 ☐ Could r	pation	th, Day, Year)	injury		? Yes 2□I	No					
Jivis	a of Attendents after deat Director:		4 Homicide	determi	ned 28e. Place	of Injury - At honing, etc. (Specify)	ne, farm, str	eet, factory, office		281	Location (S City or Tow	Street and Numb m, State)	er or Rura	Route Number,	
_ ;	within 24 hours at To the Funeral Dictoral Completely filled in	Medical	(Check 2	Medical E	Physician: To the b	sis of examination	and/or invest	tigation, in my opinic	n, death occ	curred at the	e time, date a	ind place, and di	e to the ca	use(s) and manner stated.	
T off	vithin To the comple		only one) 3 29b. Signature and t		Nurse Practitioner	r: To the best of my	y knowledge,	death occurred at the 29c. License		e and place,	and due to t	he cause(s) and 29d. Date signe			
					Mn			M73	388			12/11/	)		
	5		30. Name and addre					r <sub>int)</sub> EORGETO	ים ואווא		BETHE	SDA. M	D		
	Stat	.е	31. Date filed (Month	, Day, Year)	<del></del>	gistrar's Signatu	îre -	_	AATA KI	J., I	7111E	ODA, M	<u> </u>	1	
	Registra	ir		IEG I C	ZUII	Evens	13. A	rarks							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Madeline Caroline Trail Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Western MD Regional Medical Center Allegany Cumberland 5. Social Security Number Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Months (Month, Day, Year) 03/02/1940 Country)
Marvland 71 **Director** 218-38-0679 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Allegany Little Orleans 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 33225 Old National Pike 21766 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 💢 No Black White etc. 1 X Never Married 2 Married þ Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify. White 3 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress should be filed with and Mental Hygien 7 is marked other ti Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Milford Trail Maysel Ketterman 1 and 2 should bot Health and Meintern 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Conrad / Nephew 33225 Old National Pike, Little Orleans, MD 21766 Department of Health Important: If item 27 any injury or other to Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Piney Plains Cemetery 12/17/201 Little Orleans, MD 21. Silmature of Funeral Service Dicensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 00 Part 1. Saler the dise vie, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fallum. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami sician and burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an The law page 2 s autopsy performed certificate Hospital or Attending Physician: <sup>2</sup>4 hours after death. Funeral Director: After this certifica To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 -110 1 Tyes မ + ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident work? 1 ☐ Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one

Registrar

State

NLS

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
UEC 16 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Michael Stasko, M.D.,

Records,

**Division of Vital** 

924 Seton Drive, Cumberland, MD

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dav Jack W Tharp 2011 1:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WMHS Frostburg Nursing & Rehab. Center Frostburg Allegany Social Security Number If Under 1 Year | If Under 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year)
December 14, 1926 Maryland Director 84 220-16-6599 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18210 Borden Yard Road Funeral 21532-U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give Completed by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Trucking Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George W. Tharp Helen Folk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-Virginia Tharp Maryland 18210 Borden Yard Road Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Maryland Cumberland Crematory December 14, 2011 Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ronary Ph\_sician/ disease or condition en Medical resulting in death) Due to (or as a consequen of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Linter Underlying Cause (Disease or iinjury Due to (or as a consequence of) -transit and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician a hed for use as the bunal-Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 s performed? Yes 2 Z N or Attending Physician: The 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director, After completed filled in by the funer Natural
Accider
Suicide 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 721244 ekc 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jesus Tan 4 Broadway Street 21532 Frostburg, MD 10 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

			12/16/11, Plea	se Type or Pr	int in	Black II	ndelible l	nk. Ens	ure A	II Copie	s Are Le	gible.				
nls	, per M	Ε,	Allegany Co.	State of M												
			State Registrar			Cei	tificate of	Death			Reg. No. 2	011	42372			
	Physicia		Decedent's Name (First, Middle     Orval	, Last)		Ullery				2. Date of De	eath Pay	Vanu /	3. Time of Death			
	Medi Exami		4a. Facility Name (if not institution	give street and number)		Ollery	4b. City, Town,	or Location	of Death	10	4c. Coun	ty of Death	0030 M			
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	Funeral Director		5. Social Security Number 214-28-6474 Usual Residence of Decedent	6. Sex 7. Ag	e (In yrs. I 81	ast birthday) Yrs.	If Under 1 Yea Months Day		24 Hrs. Min.	8. Date of Bir (Month, Dan 2	7, 1930	9. Birthplace Country)	e (State or Foreign			
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	with th	sra	710 Greenwa	v Avenue			10f. Zip Code 10					10g. Citizen of What Country? USA				
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d 21	s filed within 72 hours after death with the Maryland tal Hygiene. Vo other than "natural", or Items 23a or 28a-f sho event, the Medical Examiner must be notified at	0	12 Warehouseman Manufac										turing			
lan	d be file fental rrked c	욘										1e)				
Maryland 21215-0036	12 should be filed within 72 lth and Mental Hygiene. 27 is marked other than ", rtraumatic event, the Med		19a. Informant's Name/Relationsh Michael Ullery		_	19b. Mailin	g Address (Stree	t and Numbe	er or Rural	Route Numbe	er, City or Town,	State, Zip Code	21502			
	<b>F a</b> Fe		20a. Method of Disposition	SOI			0 Green	way A				nberland MD 21502  20c. Location - City or Town, State				
Б	Page 1 nent of int; If i		1 X Burial 2 ☐ Cremation 4 ☐ Depation 5 ☐ Other (S	3 ☐ Removal from State	Su	emetery, crem	natory or other pl morial Par	ice)	D	ate 12/16/201		n-City or Town, nberland				
Baltimore,	permit, Page 1: Department of F Important; If its any injury or of		21. Signature of Funeral Service Li			22	. Name and Add	essin Facilit	ěral Ho	me. PA						
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	Physician/		23a: Part 1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.  Immediate Cause (Final disease or condition													
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68760	certific nding I use as	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of <u>pr</u> egnar	ncy				C S	224 D	ata af daliyanı	1			
Box	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Completed by Physician/Medical	in the past 12 months? 1  Yes 2 No	1 Live Birth 4 Pregnant a	2 ☐ Feta time of d	Ideath 3 eath 5	Ectopic pregnar Other (specify)	псу				ate of delivery onth Day	Year			
P.O.	at the ed by ti detach	Ę	9 ☐ Unknown  Part II. Other significant condition		ut not resu	ultina in the ur	nderlying cause o	iven in Part I		220 Did to	obacco use con	tribute to the ea	use of death?			
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Division of Vital Records,	Physician: The law i r this certificate has be aral director, page 2 s	S									rmed?	death?	tion of cause of  No			
ita	sician certifi rector	<b>m</b>	25. Was case referred to medical examiner?  1 Pres 2 No	Hospital:			T <sub>G</sub> ,	Place of Deat	h <i>(Check d</i>	only one)						
of \	g Phy er this neral d	e: To	27. Manner of Death	28a. Date of injur	у	ER/Outpatient 28b. Time of	28c. Inju	4 ∐ Nu ryat			dence 6 Oth					
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i∨is	or Att after d Direct in by	Certificate:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin		. (Specify)				2	8f. Location (S City or Tow	Street and Numb n, State)		te Number,			
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	the Ho nin 24 the Fu npleter		only one) 3 Certifying I	aminer: On the basis of ex Nurse Practioner: To the b	amination	and/or investi-	gation, in my onin	ion death on	curred at ti	he time date a	ind place and di	ie to the causels	) and manner stated.			
		1	29b. Signature and title of certifier	-Prace			29c, Licens	e number	202		29d. Date signe	10	·			
	5	-	80. Name and address of person	no completed cause of do	ath (Item	23a) (Tuna D		0 5 5	40		vec	13/	2011			
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	State Registra	r <sup>3</sup>	1. Date filed (Month, Day, Year) UEC 1 6 20	32. Registra	's Signatu	ire farts										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 37 2011 Henry W. Vetra Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4c. County of Death Dicomico Social Security Number 9. Birthplace (State or Foreign Country) Maryland **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 1 **X** M 2 □ F 01 21 1935 Director 217-30-9035 76 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7071 Levin Dashiell 21830 and Mental Hygiene. is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 X Married XYes 2 No Yes, Give US Army 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Carpenter Metal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin Vetra Margaret Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. June Vetra|wife |7071 Levin Dashiell Rd.,Hebron, MD 21830 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill Memory
Gardens Date 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12 07 2011 Hebron Maryland 21. Signature of Juneral Service Licer 22 Name and Address of Facility
Holloway Funeral Home P.A.
501 Snow Hill Rd., Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Onset and Death No Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or linjury Due to (or as a consequence of) the bunial-tran that initiated events resulting in death) Last Due to (or as a consequence of). the attending physician hed for use as the bunal Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) Day 9 Unknown g Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? After this certificate I Yes 2 Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medica examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) 1 Tes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred ak He Natural 5 Pending Accident Investigation 1 Yes 2 🗌 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 24 (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, geam occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1063199 12/3/11 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) OCTESH O HMA 910 EASTERN SHORE DR., SALISBURY MD, 21804 31. Date filed (Month Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Rita 0454 M 12 204 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Calvert Memorial Hospital Prince Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 05-06-1951 1 M 2 X F Hours Maryland Director 216-60-1367 60 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD Calvert Lusby 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20657 7741 Pine Blvd., United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 **X** No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Frances Pietrazkiewicz Armando Ballon permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rudy T. Vick - Husband 7741 Pine Blvd., Lusby, Maryland 20657 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Solomons UMC Cemetery 12/15/2011 4 Donation 5 Other (Specify) Solomons, Maryland 21. Signature of Funeral Service License Rausch Funeral Home, P. A. 22. Name and Address of Facility P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Physician/ Obstruc ay disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Pancroute Sequentially list conditions, if any leading to improve the Due to for as a consequence of if any, leading to immuon cause. Enter Underlying Cause (Disease or iinjury Exami and I-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ending physician use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year been signed by the should be detached 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 K N 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Investigation M the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c. License number 10061783 2011 30. Name and address of person who completed cause of death (Item) 23a) (Type, Print) Chang Bae Choi, MD 100 Hospital Road, Prince Frederick, Maryland 20678 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 15 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 42375 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ EORGE TERRY Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ANNE AR 49 VETERANS MILLERSVILLE Hwy. LOT 41 If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 | F Months Hours Min. (Month, Day, Year) Country) 58 **Director** Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 ☑ No HNNE HRUNDE 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 8049 VETERANS HWY LOT 41 **ユリロタ** U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. I Hygiene. other than "natural", or i ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Specify: WhITE 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) AWTENANCE MECHANIC U.S GOVERNMENT Be any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) f Health and Mental item 27 is marked o MRGE PETER WHITE YARY MARRARET METZNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORRIA SIKORSKI, SISTER 112 KUETHERO, N.E. GLENBURNIE, MD. 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of P 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Important: If 4 ☐ Donation 5 ☐ Other (Specify) 12-22-11 ODENTION, MID. ARUNDEL CREMATORY 21. Signature of Funeral Service Licens Dauaherty FUNERAL HOME 2601 MOUNTAIN RD. PASADENA, MID. 21122 23a. Part 1. Enter the sease of the caused shock, or heart failure. List only one cause on each line. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Int-shell Immediate Cause (Final Physician/ quete disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): and transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Month Day Year Pregnant at time of death ed by the g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed<sup>a</sup> death? 2 100 1 Tyes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 ျပ 1 Inpatient 2 I ER/Outpatient 3 I DOA this s after death.

Director: After this d in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending work? 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

68760

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Reg. No. . Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Month Winkles Steven Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany WMHS-RMC Cumberland If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex . Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Birthpiac Country) NY Month, Day, Yea Director 218-62-6042 1 XM 2 F 59 23a or 28a-f show 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director WV Hampshire Romney 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral HC 64 Box 130 26757 USA tems within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ò Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates 'natural", Specify 3 Widowed 4 X Divorced white the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygier is marked other t self-employed musician / writer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 1 and 2 should be if Health and Ments Dorothy C. Jewell James C. Winkles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mike Winkles WV 26757 brother HC 64 Box 130 Important: If item 27 any injury or other tra Romney 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ₽ 1 ☐ Burial 2 ☐ Xremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 12/27/20 MD Cresaptown Denation 5 Other (Specify) 22. Name and Address of Eacility Scarpelli Funeral Home, PA Signature 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one caus Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? Yes 2 No After this certificate 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: ည 1 Mnpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation within 24 hours after deat To the Funeral Director; Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 2 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42377 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 16, 2011 December 14:23 Garland Wyche Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Months Hours Min. **Director** 225-52-8208 1 🛂 M 2 🗆 F Virginia April 9, 1941 70 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits . Page 1 and 2 should be filed within 72 hours after death with the Maryland Director notified 28a-f 1 X Yes 2 No Upper Marlboro Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ items 23a or ner must be r Funeral 9405 Fairhaven Avenue 20772 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc.
African ō, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural" Completed 3 Widowed 4 Divorced American Year or Dates Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Stewart Funeral Elementary/Secondary (0-12) College (1-4 or 5+) Mortician Home, Inc. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elsie Carter Herbert Wyche 20772 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Upper Marlboro, Maryland 9405 Fairhaven Aveune Cathie Singleton - Spouse item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State Dec. 28, 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory Clinton, Maryland 2011 21. Signature of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home, Inc. 10 20019 ( 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) lancer 1 Mart Medical Examiner Cardiovascular Miles Theresc 1 year Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Dav Pregnant at time of death certificate has been signed by the a lirector, page 2 should be detached Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 No 1 Yes 212 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 욘 1√ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director; After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Side P45565 17-17-2011

State Registrar ((70/Civings for R) It sol of WARLington MD 20766

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MicHAE( SiduRous MD ((To/Lining))

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 19a per fh,g923,01/10/2012dhb
Certificate of Death

Registrar

Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ December 13, 2011 8:02 Рм Virgil T. Williams Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Waldorf Charles 302 Tumbleweed Place Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Sex 1 M 2 F 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Months Days Hours Min July 22, 1958 South Carolina Director 53 577-80-6376 Usual Residence of Decedent 28a-f show 10b. County 10a. State the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Charles Waldorf 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 302 Tumbleweed Place 20601 United States within 72 hours after death 11 Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l th and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) 12th Construction Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Williemae Jacobs Virgil S. Williams other traumatic 19a. Informant's Name/Relationship (Type, Print) Daughter-Canady 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau wife 302 Tumbleweed Place Waldorf, Maryland Patricia <del>- Ganaday</del> - Williams / Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 22 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory 2011 Clinton, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition LOPD Medical Due to (or as a consequence of): Examiner anthra Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or imjury una that initiated events resulting in death) Last trar Due to (or as a consequence of):/ attending physician for use as the buna Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown the 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an has autopsy performed? Yes 2 No prior to completion of cause of death? page 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify, this s after death.
I Director, After this d in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 🛮 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 104 old Branch Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42379 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:24am uren arie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Betherda Montaomeri Social Security Number 7. Age (In yrs. last birthday)
26 If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F 6/43th 1985 Maryland **Director** Yrs. 213-31-0712 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** ems 23a or 28a-f sh r must be notified a St. Mary's County 1 √ Yes 2 □ No Maryland Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 39835 Wrinkle Free Lane United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2¾ No
If Yes, Give Black, White, etc. or or þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify.White "natural" Completed 3 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teacher Education Be or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ္ Randall Weller Annette Wratten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Sidorowicz /Husband 39835 Wrinkle Free Lane, Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Riverdale Crematory 12/20/2011 Riverdale, MD 4 Donation 5 Other (Specify) of Funeral Service Licer Pope Funeral Home, 5538 Marlboro Pike Forestville. MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ea Onset and Death Immediate Cause (Final Ph\_sician/ letastati disease or condition resulting in death) years Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): signed by the attending physician and de detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Month Pregnant at time of death Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page To the Hospital or Attending Physician: The within 24 hours after death. performed' After this certificate 2 No XYes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita Other: 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 2 Accident
3 Suicide
4 Homicide М 1 ☐ Yes 2 ☐ No Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) 2011 D0057423

State Registrar

Box 68760

P.O.

Records,

Division of Vital

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

KRISTIN BAIRD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a & 20b & Maryla Fill / 6923 11/31/2012 all III and Mental Hygiene

		For State of Waryland / Deparement of Waryland / Deparement of Waryland / Deparement / Depar	rificate of D			. No. 2011	42380
Physici	an/	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death 4:00P M
Medi Exami	cal	Johnathan Maurice Wiggins  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death	<u>  December</u>	16, 2011 4c. County of Death	
Exami	ilei	9302 Messina Drive	Ft. Was			Prince Ge	eorge
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 216-35-8920 1 $\stackrel{\times}{\square}$ M 2 $\square$ F 20 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 09/27/19	9. Birth Cou Mary	nplace (State or Foreign ntry) 1and
and show dat	tor	10a. State 10b. County 10c. City, Town or Local	ation				10d. Inside City Limits
Mary 28a-f	irec	Maryland   Prince George's   Fort Washi					1 Yes 2 X No
with the 23a or 1st be r	Funeral Director	10e. Street and Number 9302 Messina Drive	10f. Zip Code 20744		US	g. Citizen of What Cou SA	untry?
partitiore, i Maryland ZIZIO-0000 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic.	by	11. Marital Status  1 ★ Never Married 2 ☐ Married  1 ★ Never Married 2 ☐ Married  1 ★ Never Married 2 ☐ Married  1 ★ Never Married 2 ☐ Married  1 ★ Never Married 2 ☐ Married  1 ★ Never Married 2 ☐ Married  1 ★ Never Married 2 ☐ Married  1 ★ Never Married 2 ☐ Married  1 ★ Never Married 2 ☐ Married  1 ★ Never Married 2 ☐ Married  1 ★ Never Married 2 ☐ Married	as Decedent of His Yes, specify Cubar		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Blace	, etc.
Z I Z I 3-0030 within 72 hours after jiene. er than "natural", o the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed)  [Give kill Flementary/Secondary (0-12) College (1-4 or 5+) life. DO	ent's Usual Occupa ind of work done do NOT use retired)	tion uring most of work	ing	sb. Kind of Business/lat College	ndustry
d withii dygiene ther the nt, the	Be Co	1 Studen	it I	40 Mathada Nasa	e (First, Middle, Mai		
yiand d be filed Mental Hy arked oth	70 E	17. Father's Name (First, Middle, Last)  James W. Wiggins	deri Surname)				
d 2 shouk alth and N 27 is ma er trauma				ty or Town, State, Zip ton, MD 20			
Deficiency of the permit. Page 1 and Department of Healinportant: If item any injury or othe once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ition (Name of atory or other place <b>Memoria</b>			lc. Location - City or	
Dall permit. Departi Import any inji		21. Signature of Funeral Service Licensee 22.	Name and Address	ill Rd.,	orge P. Ka Oxon Hil	alas Funer 1, MD 2074	ral Home,P.A.
Physician Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions,  b.			or respiratory arrest,		Approximate Interval Between Onset and Death
	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Out to (or as a consequence or):  C. Due to (or as a consequence of):	ny h				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	d	Ectopic pregnancy Other (specify)	1		23d. Date of deli	ivery Day Year
the dea	hysi	1   Yes 2   No 9   Unknown					
tuires that en signed I	b	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause give	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
The law required ate has been signated page 2 should be a second to be a second t	Completed	<u> </u>			24a. Was an autopsy performe	prior to c	opsy findings available completion of cause of
ysician: s certific director,	Be	25. Was case referred to medical examiner?	Othe	ce of Death (Chec	k only one)		
ding Phys ding Phys h. After this funeral di	cate: To	1	28c. Injury	4 ☐ Nursing Heat	ome 5 Residence 28d. Describe how	ce 6 Other (Speci Injury occurred	fy)
al or Attendir s after death. I Director: Af	Certificate	2 Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined   28e. Place of Injury - At home, farm, streed building, etc. (Specify)			28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
he Hospit: in 24 hours he Funera pletely fille	Medical	29a. Certifier (Check (Check only one) Certifying Physician: To the best of my knowledge, death or 2 Medical Examiner: On the basis of examination and/or investigned only one) Certifying Nurse Practitioner: To the best of my knowledge, or 3 Medical Examiner: To the best of my knowledge, or 3 Medical Examiner: To the best of my knowledge, or 3 Medical Examiner: To the best of my knowledge, or 3 Medical Examiner: To the best of my knowledge, death or 3 Medical Examiner: To the	gation, in my opinio	n, death occurred a	t the time, date and p	place, and due to the o	ause(s) and manner stated.
To tl withi To tl		29b. Signature and title of certifier  Holly Mlany MD		number 13428		Date signed (Month)	, Day, Year)
2 /		30. Name and address of Jerson who completed cause of death (Item 23a) (Type, Pr	int)	-			
Sta Registr		31. Date filed (Month, Day, Year)  92. Registrar's Signature					

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Metzler Ward December 9, 2011 9:00 Ann Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** 4c. County of Death Wicomico Parsonsburg 31763 Morris Leonard Road Social Security Number If Under 1 Year \_ If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday) 8. Date of Birth Funeral Months Days Hours Director 58 11/12/1953 Michigan 221-36-8510 Usual Residence of Decedent 28a-f shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c City Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code Citizen of What Country? Funeral USA 21849 31763 Morris Leonard Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White etc. δ 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher should be filed with and Mental Hygien is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jean Gilbert Coleman Metzler permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic e injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zio Code) 21849 31763 Morris Leonard Rd., Parsonsburg, MD 21849 Philip R. Ward/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 12/12/2011 Salisbury, MD Salisbury Crematory Donation 5 Other (Specify) Signatu e of Funer I Service Licenses Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine Due to (or as a consequence of, If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events and burial-trar resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 nding p IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy signed by the atte in the past 12 Day Month Year Pregnant at time of death No Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perfora 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) After this funeral 7. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? Natural 28d. Describe how injury occurred 5 Pending hours are death. ineral Director A 1 🗌 Yes 2  $\square$  No Accident Investigation 6 Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сотретес (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifie 29d, Date signed (Month, Day, Year,

Registrar
DHMH 17 Rev 7/2009

State

518

30. Name and address of person who completed cause of death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42382 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Williams December Valarie F. 3 2011 1220 Medical 4c. County of Death Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** KEDIONAL HICOMICO 5445641 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs **Funeral** Days (Month, Day, Year) 043-24-1003 82 Director 1 □ M 2**X** F 08/30/1929 Maryland Usual Residence of Decede 28a-f show 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 X No Wicomico Maryland Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21875 USA 301 Highland Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. py 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: er than "natural", the Medical Exam Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher should be filed with and Mental Hygien is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edna R. Hotton George Conway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or any Carla J. Hicks/Daughter 611 Homer st., Salisbury, MD 21804 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other pla Springhill Memory Gardens Burial 2 Cremation 3 Removal from State 12/20/2011 Hebron, MD Conation 5 Other (Specify) e of Funeral Service, Stewart Funeral Home by Holloway and Downey, P.A. 821 West Rd., Salisbury, MD 21801 Approximate shock, or heart failure. List only one cause Elevation myocardial Interestion set and Death mmediate Cause (Final Physician/ disease or condition resulting in death) 200 Medical Examiner Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying per pattern Due to (or as a consequence of): death certificate be executed Cause (Disease or injury that initiated events sician and burial-tran resulting in death) Last /Medical ding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death Physician/ 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ for in the past 12 months? Day Year Month Pregnant at time of death 2 No ed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsv Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ုင Certificate:

68760 Box Records, Vita Division of To the Hospital or Attending PP within 24 hours after death.

To the Funeral Director: After the commission in by the funeral

Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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State

Medical

only on

eted cause of death (Item 23a) (Type, Print)

100 E Carroll Street Salislaw M

29d. Date signed (Month, Day, Year)

Bergmueller

Registrar

Registrar

Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 2011 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

**ORIGINAL** 

O.C.M.E.

OGME

December 2, 2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 William Alan Wheatley Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Salisbur Wicomico HOSOICE th If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
DE 8 Date of Birth Age (In vrs. last birthday **Funeral** Hours Min Month, Day Year) 67 Director 221-28-6809 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 🗆 Yes 2 💆 No MD Wicomico Salisbury 10e. Street and Number rmust be r 10f. Zip Code 10g. Citizen of What Country? Funeral 126 May Dr. 21804 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc ō ģ 1 Never Married 2 Married 2 No Maryland 21215-0036 Wheatley If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: White Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Allfirst Bank Systems Analyst injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Woodeye Goldsborough Wheatley Bertha Claira Larason 19a. Informant's Name/Relationship (Type, Print) lia m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai 3300B Fuller St., 29 Palms CA, 92277 Michael Wheatley Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🛛 Cremation 3 🗋 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory |12|9|2011 Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home natu 501 Snow Hill Rd., Salisbury, MD, 21804 Dompo Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between colo Immediate Cause (Final Onset and Death Physician/ ca~c disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease of it and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ate has been signed by the atte page 2 should be detached for Month Pregnant at time of death 1 Yes 2L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) Hospice within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred at de 1 Natural 5 Pending work 1 🗌 Yes 2 No filled in by the 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical to certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and due to 29a. Certifier completed (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 63/99 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and SHURE DR, SALISBURY, MO. 21804 10 HRA

State

Registrar

31. Date filed (Month, Day, Year)

DEC 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42385 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2011 Physician/ 6:40 A M December Thaddeus Wardell, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wicomico Salisbury Wicomico Nursing Home 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number Funeral 1 🗓 M 2 🗆 F Months Davs Hours Min (Month, Day, Oct. Director 214-34-8479 Usual Residence of Decedent shov 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10c. City. Town or Location 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21801 1810 Jersev Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Force Black, White, etc. Yes 2 X No Yes, Give 1 X Never Married 2 Married Completed by Yes 2 X No Specify: 3 Widowed 4 Divorced Black Year or Dates 27 is marked other than "natur traumatic event, the Medical Baltimore, Maryland 21215-0 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ould be filed withind Mental Hygiene marked other th Fertilizer Plant aborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Thaddeus Wardell, Sr. Susie Conway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Wyche/family friend 9895 Palace Hall Drive, Apt. 420, Laurel, MD 20723 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 12/07/2011 Balisbury, Maryland 4 Donation 5 Other (Specify) Salisbury Crematory 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD tut of Funeral Service Licenses JOLLEY MEMORIAL CHAPEL 23a. Part 1. Enter the disease, or complicatio nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Day to (or as a consequence of): If any, leading to immediate cause. Enter Underlying executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna Ectopic pregnancy in the past 12 months? Month Day Year the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available 24a. Was an prior to completion death? After this certificate has autopsy performed 2 1 No 1 Yes Yes after death.

Director: After this certific in by the funeral director, 25. Was case referred to medical Be 26. Place of Death Check only one Hospital Other 2 No 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

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910 Easternshore Dr Salisbury MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahesha Thimmarayappa MD

31. Date filed (Month )

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42386 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
H-35P M Physician/ WARI Month Year VA-LISS A 201 100 Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Montgomery Sanctuary At Holy Cross Burtonville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 08/16/1933 1 □ M 2 🖾 F 76 Vrs NC **Director** 240-56-5471 Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1√2 Yes 2 ☐ No MD Silver Spring Montgomery 10g. Citizen of What Country? ò 10e. Street and Number 10f. Zip Code Funeral items 23a United States 20904 13721 Avonshire Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. ☐ Yes 2 🗓 No "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: Completed 3 X Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Ith and Mental Hygiene.
27 is marked other than 'traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Dept. of Labor Secretary Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hamilton any injury or other.

once, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) ပ Estella Cofield Rice Moses E. Rice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13721 Avonshire Lane, Silver Spring, MD 20904 19a. Informant's Name/Relationship (Type, Print) Alicia Yvette Ward/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1x Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 12/17/2011 Clinton, MD 4 Donation 5 Other (Spedify) 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Lice 5538 Marlboro Pike, Forestville,MD 20747 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Enter the disease, Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final ANCREATO BILLARY Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the Ünknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was ar autopsy perform certificate 2 No 1 Yes 1 🗌 Yes eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to predical 26. Place of Deat Check only one) examiner? Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of certifier 29b. Signature 29c. License number 28595 ulle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Y

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SmiTH.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First\_Middle\_I ast) 2. Date of Death Physician/ Month 2011 2:15A Albert Edward Yeatman, December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George Clinton Southern Maryland Hospital Center Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min 579-38-5254 1 🗓 M 2 🗆 F 83 **Director** 8/26/1928 Washington, DC Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 Yes 2 X No Maryland | Prince George Camp Springs 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 6006 Middleton Lane USA 20748 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, "natural", or iten edical Examiner r Black, White, etc. by 1 Never Married 2 X Married 2 X No ☐ Yes Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Library of Congress Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Albert Edward Yeatman, Sr. May Lowe Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karin M. Yeatman/Wife 6006 Middleton Lane, Camp Springs, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State Kalas Crematory 12/21/2011 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, MD 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic Obstructive Pulmonary Disease 6 mo disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 2 weeks Pneumonia Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did topacco use contribute to the cause of death? Completed by 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: 잍 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify eral Director: After thi filled in by the funeral 27. Manyler of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred M Natural injury work?
1 Yes 2 No 5 Pending Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 29c. License number

CR 10

Registrar
DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registr

John C. Patterson,

D19633

M.D. 7501 Surratts Rd. #201A Clinton, Md. 20735

12/15/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 42388 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month /2 Physician/ Emil Freddie Zlock, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HICAMICO 5AL 13641 TENINSULA REGIONOL 9. Birthplace (State or Foreign Year If Under 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 **Funeral** Days Director 218-40-5176 1 X M 2 🗆 F 68 April 21,1943 Maryland show or 28a-f shov notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? J Hygiene. I other than "natural", or items 23a or went, the Medical Examiner must be Funeral 902 N. Division Street 21801 U.S.A. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 Divorced white Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Roofer construction 8 ulth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Pearl Melvin Emil Freddie Zlock, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 21804 300 Brookdale Drive Salisbury, MD Tracey Zlock West (Niece) other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 = 0 1 🗌 Burial 2 🛣 Cremation 3 🗌 Removal from State Department of Important: If any injury or once. Crematory of Delmarva 12-6-2011 4 ☐ Donation 5 ☐ Other (Specify) Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 E. Grove Street Delmar. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death JNG CANCER Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed Were autopsy findings available 24a. Was an prior to completion of death? has perform 1 Yes 2 No 1 Yes Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Inpatient 2 IV ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner M. Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending death. 1 Yes 2 No Investigation Accident 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and the of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EKN SHERE DK, SALISBURY MU

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death December 5, 2011 Physician/ 10:35 PM Etta Maye Zoerb Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Mount Airy Kline Hospice House If Under 1 Year If Under 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Days (Month, Day, Ye, 1 🗆 M 2 🕱 F Months Hours Maryland 92 โ′919 **Director** Nov. 219-01-2069 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21701 6711 Fish Hatchery Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Force Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 XNo Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 12 should be filed within 72 now.c... alth and Mental Hygiene. A 27 is marked other than "natural" "natural" Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Milton Frank Staub Etta Maye Stoops 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shament of Health ar tant: If item 27 is 20230 Trovinger Mill Rd., Hagerstown, MD 21742 Paula Schofield / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or ot Dec. 1 🔲 Burial 2 🛛 Cremation 3 🗋 Removal from State Frederick, Maryland 4 Donation 5 Other (Specify) Resthaven Crematory 2011 21. Signature of Fundamental Service Licensee Resthaven Fufferal Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease, shock, or head failure. Usi Immediate Cause (Final disease or condition resulting in death) complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death only one cause on each line Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to forms a nonsequence off cause. Enter Underlying Exami Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 You Year Month Day Pregnant at time of death the 9 Unknown 9 Unknow signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) House Hospital 1 Yes 2 XNo မြ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Deal 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Tes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature ar e of certifier 29d. Date signed (Mo. who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

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Please Type or Print in Black Indelible Ink 5 Frank All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** ROBERT 08:384M BENTLEY DECEMBER 2011 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1**X** M 2□F 223-40-1417 76 Oct. 16,1935 Virginia **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland or 28a-f show notified at 10d. Inside City Limits 10b. Count 10c. City, Town or Location 1 ☐ Yes 2 🛣 No Director MD Baltimore Edgemere 10e. Street and Number 10f. Zip-Code 10g, Citizen of What Country? ö items 23a or 9104 North Point Road 21219 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. Examiner 1 Never Married 2 Married 1X Yes 2 □ No If Yes, Give Year or Dates: 1958–62 ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years <u>Mechanical</u> Engineer Engineering other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) Be Robert E. Bentley, Jr. Della Bishop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms Deborah Bentley (Daughter) 9104 North Point Road Edgemere, Maryland 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Removal from State 2 ☐ Cremation 3 ☐ Removal from State Crownsville V.A. Cem. 1/4/2012 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature f Funeral Service Licens 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Part 1. Enter the disease, shock, or head failure. 7922 Wise Ave. Dundalk, Maryland se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest test only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca per linal disease or condition Physician Alhedical HERNIATION BRAIN 5 HOURS resulting in death) Due to (or as a consequence of) Examiner HNOXIC BRAIN INJURY 6 HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) HYPERTENSIVE ATHERUSCLEROTIC \ DISEASE and CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) iding physician Division of Vital Records, P.O. Box 68760 Physician/Medical or Attending Physician: The law requires that the death certificate be as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 XYes Hospital: 1 Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 ER/Outpatient 3 DOA မ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 2 Accident 1 Yes 2 No filled in by the Director 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) hours after To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 DECEMBER 24,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATIL, MD 4940 Eastern Avenue, Baltimore, MD, 21224 KAUSTUBHA 31. Date filed (Month, Day, State **DEC 2 9 2011** Registrar

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Box 68760 e death certificate b the attending physi ed for use as the bu	Physic	1 Yes 2 No 9 Uni			<sup>eath</sup> 5	Other	(Specify)							
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Division of Vital Records, P.O. Box 68760 To the Bospital or Attending Physician: The law requires that the death certificate to within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu	dical		nysician: To the bes										•··-=(=)	
To th withi To th	Medi	- 63	miner: On the basis of and manner st	ated.	III CO/OF INV	esugation			ed at the time					_
	~	29b. Signature and title of certifie	ч				29c. License			- 1	29d. Date signed			
		シーベレー	Manage .				0.C.N	ı. E.			December 30	, 201		
(A)		<ol> <li>Name and address of person</li> <li>Donna M. Vincenti, M.</li> </ol>	Assistant M		,	900 \/	Baltimore	Street Ba	ltimore M	ID 212	23			
9,0	ate	31. Date filed (Month, Day, Year)	32. Re					J. 1001, De						_
Regist	rar	JAN 0 5 20	12 June	gistrar's Signati	Loa	Jan J								

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42392 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jewel Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Laurel Prince Georges 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year
July 4, 1 **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 🗆 M 2🏗 F Months Days Hours Min. 80 258-48-6952 Yrs. Director July Ĩ′931 Georgi Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No MD Montgomery Silver Spring 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 22 Baileys Court 20906 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ō ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Black "natural" 3X Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working d Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cook Oglethorpe Club or other traumatic event, Be Page 1 and 2 should be filed went of Health and Mental Hygant; If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Fred Lavant Artelia Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenda Brown - Daughter Baileys Court, Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 1-7-2012 4 ☐ Donation 5 ☐ Other (Specify) Beautiful Zion Pembroke, Georgia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Craig R. Tremble 66 Ledford Street, Pembroke, Georgia 31321 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Peath Physician/ disease or condition resulting in death) m' Medical Examiner Due to (or as a consequence of): Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transi Cause (Disease of Tinjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Investigation Accident within 24 hours after deat To the Funeral Director: completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) D54223 27 7300 Van Dusen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd. aurel, Q Regional Hospital, Emergency aurel ian 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ b Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 2 South Payson Street **Baltimore** 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Days Min Months Hours 1 🗆 M 2 💆 F 220-18-4024 84 SC Director Aug 12, 1927 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No MD **Baltimore City Baltimore** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2 South Payson Street 21223 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black If Yes, Give Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) **Own Home** d 2 should be filed with alth and Mental Hygien 27 is marked other th Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 **Binkey McCray** Kelly McCray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other 839 Woodward Street. Baltimore, MD 21230 Rodney Ben 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1  $\blacksquare$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State cemetery, crematory or other place) Dec 28, 2011 Owings Mills, Md. **Garrison Forest Veterans** 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licer 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 eart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each link. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ End Stage Parkinson's disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of. and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burial physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months? Year Month Day Pregnant at time of death 9 Unknown 9 I Inknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pending after death. Director; At 2 🗆 No Investigation the Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier 🔭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner; Tathe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and time of License number

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

5

ho completed cause of death (Item 23a) (Type,  $B \in B$ 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ STEVEN WILLIAM BABIKOW Month DEC 2ี่8 9:52P M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 5123 KING AVENUE BALTIMORE COUNTY 8. Date of Birth (Month, Day, Year) Dec. 9,1972 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Maryland 39 218-72-0151 Director 1 🗶 M 2 🗆 F Dec. Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location Director notified Baltimore County Baltimore Maryland 1 Yes XX No 28a-f BABAKOU 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 21237 USA 5123 King Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Page 1 and 2 should be filed within 72 hours after dear ment of fleath and Mental Hygiene. anart: If item 27 is marked other than "natural", or iten uny or other traumatic event, the Medical Examiner. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1XX Never Married 2 Married 1 ☐ Yes XX No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Wholesale Flower Business 12th grade N/Ă Greenhouse Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Donald William Babikow Deborah Anne Smilev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Donald Babikow (Father) 9212 Nottingwood Rd. Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 1-3-2012 Baltimore. Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Deat LUNG CANCER CELL Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Removaliable liet according a Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Month Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy s certificate has the director, page 2 s performed? 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 
Yes 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t completely filled in by the funera Natural 5 Pendina 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) To the 29b. Signature and title of certifier 29c. License number Kao 057703 uman 151 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste 2000 Fratinore

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ ESL Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 5912 Fenwick Ave. N/A Baltimore 9. Birthplace (State or Foreign Country)

VA If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 1/29/1941 Months 234-66-2034 Director 1 M 2 X F 70 Yrs. 28a-f show 10d. Inside City Limits 10c. City, Town or Location at 10a. State Director N/A must be notified Baltimore MD1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ö 23a Funeral 21239 USA 5912 Fenwick Ave. items death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Examiner Armed Forces?

1 Yes 2 No Black, White, etc or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after Black er than "natural", c , the Medical Exam 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 I and Mental Hygiene. 7 is marked other than "r Baltimore City College (1-4 or 5+) Elementary/Secondary (0-12) Public Schools Teacher 12th yrs. other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Arthur White, Sr. Ruby Pearl Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 5912 Fenwick Ave. Baltimore, MD 21239 Elmer Barksdale- Husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 11/14/2011 OwingsMills, MD Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> March F/H East 1101 E. North Ave. Baltimore, MD 21202 21. Signature of Funeral Service Licensee Brank Miller North Ave. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are utilise in death). Due to (or as a consequence of): Examine and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical certificate be Box 68760 the as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day 5 Other (specify) Pregnant at time of death the be detached P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 1 Yes 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 1 Natural 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 2 🗆 No within 24 hours after death.

To the Funeral Director: A Accident Suicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title

Registrar
DHMH 17 Rev 06-2011

State

filed (Month, Day,

rson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ 1032 PM heresa reem ber 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore of 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** 1 M 2 SF Months Days Hours Min. 20-80-651 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or important: if item 27 is marked other than "natural", or items 23a or mijory or other traumatic event, the Medical Examiner must be rones. Funeral U.S Lane 21207 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Was Deceue... \_ Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 ☐ Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Tell 040 RR Page 1 and 2 should I ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mordan Baltimore, 20c, Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 13 2012 Signature of Funeral Service Licensee Services War 170 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. arryhimia Cardine houp disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** entricular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed the burial-trans and Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 been signed by the attending problem is should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed page 2 s certificate 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examirer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔲 No ၉ 1 Inpatient 2 FR/Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending 1 Natural Accident
Suicide within 24 hours after death.

To the Funeral Director: A Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 0021730 who complet d cause of death (Item 23a) (Type, Print) 30. Name and address of perso Sinai Hospital of Baltimore a 31. Date filed (Month, Day, Year. 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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Kreek Y

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42397 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Unにいっ Physician/ Year rester DOPEr Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death County of Death **Examiner** Baltimor NM was VI 2130 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10 / 20 / 1933 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 218-28-3862 Months Country) Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Baltimore 1 X Yes 2 No MD 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 23a Funeral 540 USA items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married "natural", or ģ Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Eastern Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the abover tainless other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ucill ooper 19b. Mailing Address Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore Ave. Marview DOPEL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 1 Burial 2 Cremation 3 Removal from State 2012 DWINGS MILLS. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March FIH East Himore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) monan Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed Cause (Disease or iiniury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physiciar Physician/Medical the as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery or in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day sate has been signed by the page 2 should be detached g 🗌 Unknown Part 🖟 🎗 ther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed after death. Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 2 No Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 1 Yes 2  $\square$  No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier ac 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009 ate filed (Month, Day, Year)

JAN 0 5 2012

Box 68760

P.O.

of Vital

Division

ameda

390

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Date of Death . Decedent's Name (First, Middle, Last) Physician/ OMAR Medical acility Name (if not institution, give street and number) 4b.\_City, Town, or Location of Death 4c County **Examiner** Garden easan HIMOLE Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 250-01-3719 Hours Min **Director** 1 X M 2 □ F 6 28a-f shov 10b. County must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Hmore ō the Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Black Specify: Completed 3 X Widowed 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life., DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the second of the Secondary (0-12) College (1-4 or 5+) ΝI Be Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dman 19a. Informant's Name/Relationship ype, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Baltimore, ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune & Service Licensee 22. Name and Address of Facility 1101 E. North F/H 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph. sicia.../ disease or condition resulting in death) Medical Due to (or as a conseque ce of): Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran Due to (or as a consequence of): burialphysiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ó in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death n signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy performed? 24a Was an this certificate has 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of De th 28b. Time of 28a. Date of injury Certificate: 28c. Injury at work? 28d. Describe how injury occurred After (Month, Day, Year) injury 1 Natural 5 Pending 2 No s after death. 1 Yes Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by 4 Homicide determined within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a License number

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type,

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anna Baltimore Washington Medical Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, 212-36-5417 **Director** 1 M 2 M 12 O. Maryland 28a-f show 10a. State marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 210 othert Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced Completed Jack Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) alth and Mental Hygiene. 27 is marked other tha ASHIEL rastroad or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ laylor ee ontgomers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cole) Rothert Michelle item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it 1 Burial 2 Cremation 3 Removal from State Selma Memorial Gardens 01/05/2012 Selma, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility PICHARD LARCIS FUNK HM & CREMATION SEVES 122 W. BARSEE ST. 21. Signature of Juneral Service Lice Llean lelua ZEBULON, NC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) (ore Medical Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ☐ Pregnant at time of death☐ Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b director, page 2 s autopsy death? 1 Yes 2 No 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospita 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify After this s after death.

I Director: After this id in by the funeral d 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 X Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, thin 24 hours after the Funeral Direct mpletely filled in b determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one MD of person who completed cause of death (Item 23a) (Type, Print) State Registrar DHMH 17 Rev 06-2011

X

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

iyon Campbell		State 1-For State Registrar	of Maryland		artment of <i>rtificate of</i>			Mental H		eg. No. 20	11.4240
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last)							2. Date of Deat Month December	Day Year	3. Time of Death 2209 hrs
		4a. Facility Name (if not institution, givé street and number)  4b. City, Town, or Lo 2802 West Garrrison Avenue  Baltimore						ocation of Death		4c. County of De	wath N/A
Funeral Director		5. Social Security Number 6. Social Security Number 1. Social Security	9x 7. Age	e (In yrs. la	ast birthday) 3/ Yrs.	If Under Months		If Under 24Hrs Hours Min	_	th(MM/DD/YYYY) 9. 15,1980	Birthplace (State or reign Country) Mary land
d how any		Usual Residence of Decedent  10a. State  10b. County	1/A	10c. City,	Town or Location	on	Bo	Himor	e	,	10d. Inside City Limits 1 Yes 2 No
with the Maryland ms 23a or 28a-f show be notified at once.	Director	10e. Street and Number 2802 W. Gar	rison A	ve.		10f. Zip (	Code	Himor 21215	_ 10	0g. Citizen of What C	ountry?
or ite	by Funeral	11. Marial Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify or	1 Yes 2 If Yes, Give Year or Dates:	No	If Ye	es, specify	Cuban, M	Mexican, Puerto specify:		14. Race - An White, etc Specify:	Black
5-0036 led within 72 hours after Hygiene. other than "natural", other than the Medical Examine.	Completed	Elementary/Secondary (0-12)	College (1-4 or 5			st of work	ing life. D	ONOT use ret	ired)	NA	A
MD 21215-0036 2 should be filed within 7 h and Mental Hygiene. 27 is marked other than imaric event, the <u>Medica</u>	8	17. Father's Name (First, Middle, Last) Leona d Cam  19a. Informant's Name/Relationship (1)	pbell_		19b. Mailing	Address		Amilia	er Ha	Maiden Surname)  Trington  ber, Cit, or Town, St	ate Zin Code) 4/2/8
MD nd 2 sho alith and alith and aumati		Amielier Harr 20a. Method of Disposition	ington-n	20b. F	Place of Disposit	ion (Name	irk	Heigh		#-812_ Bo	eltimore Md.
Baltimore, permit. Pages la Department of He Important: If ite injury or other tr		1 Burial 2 Cremation 3 4 Donation 5 Other Specify 21. Signature of Jureal Service Co	:	te M	Prematory or other Zion 22. Na	arme and A	Met.	ery 1	7/12 Ker Fi	Landsde megal Ho	whe Maryland
Physician Medical	1	23a. Part I. Enter the disease, of comp failure. List only one cause on ea	ach line.			e mode of	dying, su	ich as cardiac d	or respiratory arre	est, shock, or heart	Appro ate Interval Between Onset and Death
Examiner		or condition resulting in death)	Guns hot wound  Due to (or as a conse								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse								
		d.		querice or	<i>)</i> .						
be be	Medical	UNPENDED	AMENDED  23c. If yes, outcom	e of pregr	nancy			_		23d. Date of deliv	ery
Box 6876( ne death certificate the attending phy, ned for use as the b	Physician/M	Sb. Was decedent pregnant in the past 12 months?  No 9 Unknown	1 Live birth 4 Pregnant at the second of the	ime of dea	oth -	al death er (S <i>pecil</i>		Ectopic pregna	ancy	Month	Day Year
B, P.O.  ires that the signed by the detache	ক্র	Part II. Other significant conditions	contributing to death	but not re	esulting in the ur	nderlying o	ause give	en in Part I.			to the cause of death? robably 4 Unknown
Division of Vital Records, P.O. Box 6876. Hospital or Attending Physician: The law requires that the death certificate 24 hours after death.  Funeral Director: After this certificate has been signed by the attending phy tely filled in by the funeral director, page 2 should be detached for use as the be	Completed								1 ✓ Yes	sy prior t med? death	
Vital Rec	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	lospital: 1 Inpatier	nt 2 🗌	ER/Outpatient			Death (Check		Residence 6 🗸 Ot	her: Scene
ion of tending Pheath.	-	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigati	28a. Date of Injur (Month, Day Ye Dec 28, 2011		28b. Time of In 2201 hrs		c. Injury a	at Work?	28d. Describe r Subject subj	now injury occurred ject	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could not determine	be 28e. Place of Inju	•			office build	•	or Town, S		Rural Route Number, City altimore, MD
To the Hospital within 24 hours: To the Funeral completely filled	न्न	( one on only	ian: To the best of my On the basis of exame and manner stated.	_							
F 3 F 3	\$	29b. Signature and title of certifier	11)	1	7		License n O.C.M.			29d. Date signed (i	
		30. Name and address of person who Zabiullah Ali, M.D. Assi	completed cause of destant Medical Ex			altimore	Street	, Baltimore,	MD 21223		
Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registrar	s Signatu	1. Bar	Ked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		Mental Hygiene					
			Registrar	rtificate of Death		Reg. No. 2				
	Physicia		1. Decedent's Name (First, Middle, Last)  Nancy S. Davies		2. Date of Death December 3	70, 2011 3. Time of Death 1:50 A M				
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c.	County of Death				
757	<i>t</i>		Riderwood Assisted Living	Beltsville		ince George's				
	Funeral Director		5. Social Security Number  159-22-8356  6. Sex 1 □ M 2 ☒ F  7. Age (In yrs. last birthday) 88  Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth Jan • 22, Year) 9	9. Birthplace (State or Foreign Pennsylvania				
1:			Usual Residence of Decedent							
	ıryland I-f sho ied at	Director	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 1 X Yes 2 □ No				
	he Ma or 28a e notif		10e. Street and Number	10f. Zip Code	10g. Citi	tizen of What Country?				
	with t	Funeral	3160 Gracefield Road	20904	U.S	5.A.				
	death ritem iner m	/ Fur	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.				
036	s after "al", o Exam	d by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 2X No Specify:		Specify: White				
2-0	hour natur	plete	15. Decedent's Education 16a. Dece	dent's Usual Occupation kind of work done during most of work	ing 16b. Ki	ind of Business Industry				
121	thin 72 ane. <b>than</b> '	Completed	Flementary/Seconday (0-12) College (1-4 or 5+) life. D	istrative Assistan		edical				
d 2	led wi Hygie other ent, tl	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden S	Surname)				
/lan	d be fi Mental arked atic ev	욘	Harold J. Sloman	Alice E	. Burgoyne					
Mar	shoul h and 7 is m trauma		/	ng Address (Street and Number or Run						
e,	and 2 Healt tem 2		20a. Method of Disposition 20b. Place of Dispo	Edinborough Rd.,		ocation - City or Town, State				
E E	Page 1 nent of int: If i		1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State   cemetery, cred 4 ☐ Crandviev   Grandviev	matory or other place)		nstown, PA				
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			2. Name and Address of Facility icking-Treece-Benr 21 Menoher Blvd.,	ett Mortuar	The Inc.				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.			Approximate Interval Between				
~~	Physician/		Immediate Cause (Final disease or condition Congestive Cardion	ntopathy		Onset and Death				
and the same	Medical Examiner		resulting in death)  Due to (or as a consequence of):  Atherosclerotic Co	ardioveceular Disc	250					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	alulovaseulai Disc						
x	cuted nd ransit	Examiner	Cause (Disease or iinjury that initiated events c.							
_	eath certificate be executed attending physician and for use as the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of):							
200	icate by physics the b	ledic	d							
Box 687	ending	an/N	IF FEMALE: 23b. Was decedent pregnant  1 ☐ Live Birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy		23d. Date of delivery				
Bo	e death the att	Physician/Me		Other (specify)		Month Day Year				
P.O.	requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco u	co use contribute to the cause of death?				
ds,	quires en sign ould be	ted k	Chronic Obstructive Pulmonary Diseas	e	1 🛣 Yes 2	2 No 3 Probably 4 Unknown				
COL	has be	Completed	Atrial Fibrillation		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?				
8	sician: The la certificate ha rector, page		25. Was case referred to medical		performed?					
Vita	ysicial s certi	To Be	examiner?  1  Yes 2 No	26. Place of Death (Checont 3 DOA Other:	ome 5 Residence 6	Other (Specify)				
of	nding Physician: 1 th. : After this certifics ? funeral director, p	ite: T	27. Manner of Death  1 X Natural 5 □ Pending  28a. Date of injury  (Month, Day, Year)  28b. Time o injury		28d. Describe how injury					
ion	or Attendi after death. Director: A in by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 🗆 Yes 2 🗆 No	204 Leasting (Street on	nd Number or Rural Route Number,				
Division of Vital Records,	spital or Attend ours after death eral Director. / filled in by the f		4 Homicide determined building, etc. (Specify)	eet, factory, office	City or Town, State					
_	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending placemplated filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director.	Medical	29a. Certifier (Check 2 ☐ Medical Examiner: On the best of my knowledge, death only one)  3 ☐ Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred a	t the time, date and place	e, and due to the cause(s) and manner stated.				
	To the To the comp	2	29b. Signature and title of offiner	29c. License number	29d. Da	ite signed (Month, Day, Year)				
			· Suxu	D24235	Dece	mber, 30, 2011				
	15			110 Gracefield Rd	., Silver S	pring, MD 20904				
	Stat Registra	te ar	31. Date filed (Month, Day, Year)  JAN 0 5 2012  Leave f. Again	Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30 2011 Physician/ DAVIS DECEMBER 10:30 PM RONA Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S 6502 LAKE PARK DRIVE GREENBELT Social Security Number 8. Date of Birth (Month, Day, Y JULY 28 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday) Days 1 🗆 M 2 🗓 F Min. NEW JERSEY Yrs Director 55 152-50-6573 Usual Residence of Decedent 28a-f show 10h County 10a, State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1x Yes 2 ☐ No GREENBELT MD PRINCE GEORGE'S ö 10e. Street and Number 10g, Citizen of What Country? 23a Funeral USA 6502 LAKE PARK DRIVE 20770 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc "natural", or 1 Never Married 2 Married Completed by 1 Yes If Yes, Give filed within 72 hours after 2 X No Baltimore, Maryland 21215-0036 Specify: BLACK 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE CUSTOMER SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ ERNASTINE RANDALL SIMON BLOCKER 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6502 LAKE PARK DRIVE GREENBELT, MARYLAND 20770 DEVINA DAVIS/DGT. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a
Department of E.
Important: If ite
any injury or ott Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 01/05/2012 RIVERDALE, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signat ne of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between One t and Death Immediate Cause (Final Danvineas Physician/ unknown disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed and Due to (or as a consequence of): physician Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No signed by the atte Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed? 2 XNo 2 🖾 No Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: ပ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home 5 M Residence 6 Other (Specify, completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending Division s after death. I Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital o within 24 hours aff To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

(Check

29b. Signatur

only one

31. Date filed (Month, JAN

and title of ertifie

npleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number M0039 262

50 F St NW # 3300 Wash OC 20001

29d. Date signed (Month, Day, Year) JANUARY 4, 2012

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	partment of Health are artificate of Death	nd Mental Hygie	ene 2011 42403							
	_		Registrar  1. Decedent's Name (First, Middle, Last)	0.0-4(0	Reg. No.								
н	Physicia Medic	in/	Kathleen Edwards	Day ZG ZOII 11: 46 AM									
- Salar	Examin		4a. Facility Name (if not institution, give street and number) University of Maryland Medical Center	4c. County of Death									
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24	Hrs. 8. Date of Birth	Birthplace (State or Foreign							
١.	Director		082-68-7088 1 □ M 2½ F 28 Yrs.	Months Days Hours	Min. (Month, Day, Ye Feb 26,								
	and show d at	tor	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits							
	e Mary 28a-f notifie	Director	MD Prince George's Laure1  10e. Street and Number	10f. Zip Code		1 ☐ Yes 2 ☒ No							
	with the		251 Red Clay Road	20724		g. Citizen of What Country?  USA							
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	d by Funeral		Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P  1 Yes 2 XNo Specify:		14. Race - American Indian, Black, White, etc. Specify: Black							
Baltimore, Maryland 21215-0036	hin 72 hours ne. than "natur e Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	edent's Usual Occupation kind of work done during most of DO NOT use retired)	f working	Sb. Kind of Business/Industry							
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ylan	id be fii Mental arked atic ev	မ	Antoine C. Louinis	Ghi	islaine Amer	oise							
Mar	2 shou th and ?7 is m traum:			ing Address <i>(Street and Number o</i> ll <b>Red Clay Rd.</b> I		ity or Town, State, Zip Code) 20724							
re,	1 and of Heal item 2		20a. Method of Disposition 20b. Place of Disp			Oc. Location - City or Town, State							
timo	tment trant trant if		4 □ Donation 5 □ Other (Specify) Pinelawn	Mem. Park 1		Farmendale, NY							
Ball	permit Depar Impor any in	IJ	21. Signature of Funeral Service Licensee Mul 284	2. Name and Address of Facility 9222 F1at1a	Guarino Fun ands Avenue								
	Physician/ Medical Examiner	r	23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, b.	:	rdiac or respiratory arrest,	Approximate Interval Between Onset and Death							
9. D.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burus after death.  Within 24 burus after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ıysician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or nipury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  d.										
Division of Vital Records, P.O. Box 687	requires that the death certific been signed by the attending is should be detached for use as		ysician/Me	hysician/Me	hysician/M		hysician/Me	hysician/M	hysician/Me	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	☐ Ectopic pregnancy ☐ Dther (specify)	
ds, P.C	quires that ten signed bould be deta	ted by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death?							
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on of	To the Hospital or Attending Physician: The law within 24 burus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 was a completely filled in by the funeral director, page 2 was a completely filled in by the funeral director.	Certificate: T	27. Manner of Death  1 S Natural 5 Pending 2 Accident Investigation  28a. Date of injury (Month, Day, Year)  28b. Time (Month, Day, Year)		28d. Describe how								
Divisi	ital or Atte urs after de ral Directo lled in by t		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)								
	the Hosp thin 24 hou the Fune mpletely fi	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death only one) 3 Certifying Nurse Practitioner: To the best of my knowledge only one) 3 Certifying Nurse Practitioner: To the best of my knowledge of the control of the best of my knowledge only one of the control of the	stigation, in my opinion, death occu e, death occurred at the time, date a	urred at the time, date and pand place, and due to the c	place, and due to the cause(s) and manner stated. cause(s) and manner as stated.							
	¥ ≥ ₽ 8		29b. Signature and jitle of certifier	29c. License number AU41764354	U101570 De	ecember 26 2011 cultyyare, MD 2120							
	Q		30. Name and address of person who completed cause of death (Item 23a) (Type, Beth any Weller MD 2 2 500 31. Date filed (Month, Day, Yeal) 32. Remarks Signature	th Greene	Street Bo	cultimore, MD 21201							
	Stat Registra		.IAN 0 5 2012	harles									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Leslie Mark Ernest 10:40A M Medical December 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington 903 Israel Creek Court Knoxville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Age (In yrs. last birthday Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 192-44-5914 Director 1 🛛 M 2 🗆 F Yrs. 57 08/01/1954 Pennsylvania 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 X No Washington MD Knoxville 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 903 Israel Creek Court 21758 U.S.A. should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than " College (1-4 or 5+) Elementary/Secondary (0-12) Mental Hygiene. IT Consultant Computers marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ W. Ε. Bossinger Max Ernest Mary off. Page 1 and 2 shouse of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea J. Ernest / Wife Israel Creek Court, Knoxville, MD 21758 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Important: If it any injury or o cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry Hanover, Maryland 01/04/2012 21. Signature Funeral Se ice censee Anatomy Gifts Registry 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physiciani Dancreati months Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or injury signed by the attending physician and detached for use as the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy after death. 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Certificate: To 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending injury 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral D Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 06-2011

S areene St

Baltimore MD 21201

ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

aomi

31. Date filed (Month, Day, Year)

22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 5 per fh. 9923 1-19-12 sm State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 31, 2011 12:33 PM Fincham December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday, **Funeral** Days 1 **X** M 2 □ F **Director** Dec. 31, 1961 Virginia Yrs 50 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location the Maryland notified at Director 1 Yes 2 No VA Rapidan Culpeper 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō r than "natural", or items 23a or the Medical Examiner must be r Funeral 23384 Cedar Ridge Road 22733 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify If Yes Give White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Foreman Construction other t Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I ပ္ Arthur Fincham Dottie Mae Bowers ge 1 and 2 should be at of Health and Men If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Fincham - Wife 23384 Cedar Ridge Road, Rapidan, VA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury or Department Important: If any injury or Fairview Cemetery 1-6-2012 Culpeper, VA 4 ☐ Donation 5 ☐ Other (Specify) Found and Sons Funeral Chapel 22. Name and Address of Facility Signature of Funeral Service License 22701 850 Sperryville Pike, Culpeper, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Diabetes burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 as the IE EEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? for Month Dav Year Pregnant at time of death Yes 2 No ate has been signed by the page 2 should be detached g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar Hospital or Attending Physician: The law 124 hours after death.
Funeral Director: After this certificate has t autopsy perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 

Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D67355 12 - 31 - 1130. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel Kenneth Sherk 1500 Forest Glen Road, Silver Spring, MD 20902 31. Date filed (Month, Day Year) JAN 0 5 2012 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month December James Augustus Greene Sr. 2011 5:05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Seasons Hospice Randallstown Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, ) 6–27–1923 Birthplace (State or Foreign Country) **Funeral** Min **Director** 215-18-5705 1 🕅 M 2 🗆 F 88 MD Usual Residence of Decedent show 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No Randallstown MD Baltimore ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rms 23a or Funeral 4011 Paigeview Road 21133 USA items : be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces?

1X Yes 2 If Yes, Give Year or Dates. Black, White, etc ö þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: African-American "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12th Small Arms Repair Fort Meade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. Edward Greene traumatic Virginia Flannagan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Greene/Wife 4011 Paigeview Road, Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Ponation 5 Other (Specify) Glen Haven Memorial Park 1-10-2012 Glen Burnie, MD 21. Signature of Fun all Service 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Carcinoma Physician/ hung disease or condition Medical resulting in death) Due to (or as a con a quence of Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Exami Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 2 No 1 Yes Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) 6 4 Other (Specify) 2 4 Hospital: Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending ours after death.

leral Director: Aft 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signaturé 29c. License number 29d. Date signed (Month, Day, Year) WW43371 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 203 21209 New MILTIHOLE. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Patient thrown As Howard, Joseph m,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.										
		-	For State	State of Maryland	d / Department of H Certificate of D	Mental Hygiene  Reg. No. 2011 42407				
	Physicia		1. Decedent's Name (First, Middle, L.		oward	2. Date of Death	3. Time of Death			
	Medic Examin		4a. Facility Name (if not institution, gi	ve street and rlumber)	December 31 20					
	Funeral		Sinal Hospital  5. Social Security Number 6.	Ot Balt, Mor Sex 7. Age (In yrs. la		If Under 24 Hrs.	8. Date of Birth	g. Bir	thplace (State or Foreign	
	Director		212-36-0183 1 DM 2 F 72 Yrs. Months Days Hours Min. Dec. 24 1989 Country Sual Residence of Decedent							
	the Maryland or 28a-f show e notified at	Director	10a. State 10b. County Maryland	1/A 10c. City	, Town or Location	altimor	e		10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	with the s 23a or ust be n	Funeral D	3601 Fords L	are Apt. 10	7 10f. Zip Code	21215	1	0g. Citizen of What Co	ountry?	
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once.	[출]	11. Marital Status  1 Weight Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1	. 13. Was Decedent of His If Yes, specify Cubar 1  Yes 2 No	, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Black		
Maryland 21215-0036	within 72 hou giene. <b>er than "nat</b> i <b>; the Medic</b> a	Completed	15. Decedent's (Specify only highest ( Elementary/Seconday (0-12)		16a. Decedent's Usual Occupa (Give kind of work done di life. DO NOT use retired)		ing	16b. Kind of Business Baltimore	e City	
yland	ild be filed Mental Hy tarked oth atic event	To Be	17. Father's Name (First, Middle, Last Frederick t	loward		18. Mother's Nam Lelia	e (First, Middle, M	aiden Surname)	3 P 2 2 1 1	
, Mar	and 2 should Health and Mi em 27 is mar ther traumati		19a. Informant's Name/Relationship  Douglas Howa	Type, Print) brother	19b. Mailing Address (Street a. 5491 TVR)	nd Number or Run		City or Town, State, Zi		
Baltimore,	Page 1 ar nent of Hu ant: If iter ary or oth		20a. Method of Disposition  1 W Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	ace of Disposition (Name of Impetery, crematory or other place	9)	Date 2	20c. Location - City of andsdow		
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Lice	n farker	22. Name and Address	s of Ficility Par	Ave. Be	ettimore,	Maryland	
	Physician/		23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused the death one cause on each line.	. Do not enter the mode of dying	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death	
P	Medical Examiner		resulting in death)	Due to (or as a consequence)	ence of):	Heart	Dise 4.	5 0		
	ted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a conseque		77.5	7/70-4	11		
0	be executed sician and burial-transi		that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
928	rtificate ing phys as the	/Medi	IF FEMALE:							
. Box 68760	Attending Physician: The law requires that the death certificate be a reactor. After this certificate has been signed by the attending physicis by the funeral director, page 2 should be detached for use as the burn	by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan  1  Live Birth 2 Fetal  4  Pregnant at time of de	death 3 Ectopic pregnancy	<i>y</i>		23d. Date of de Month	Day Year	
ds, P.O.	requires that the peen signed by should be deta	ed by Pl	Part II. Other significant conditions	contributing to death but not resu	Ilting in the underlying cause give	en in Part I.		acco use contribute to	o the cause of death? Probably 4 Dunknown	
Division of Vital Records,	sician: The law requi certificate has been irector, page 2 should	Completed					24a. Was an autops perform	prior to death?	stopsy findings available completion of cause of	
ital	iysician: iis certifica director, I	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	Othor	ice of Death (Chec	k only one)			
of V	iding Phys th. After this funeral dir	te: To	27. Manner of Death		28b. Time of 28c. Injury	4 L Nursing Ho	ome 5 🗌 Resider 28d. Describe hov	nce 6 Other (Spec w injury occurred	eify)	
ion	ttendin death. stor: Aft the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigativ 3 Suicide 6 Could not	on he	M 1 🗆 🗅	Yes 2 □ No				
Divis	vital or A urs after ral Direc lled in by		4 Homicide determined	building, etc. (Specify)			City or Town,		4	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	(Check 2 Medical Examonly one) 3 Certifying Nu	ysician: To the best of my knowle niner: On the basis of examination rse <b>Practione</b> r: To the best of my	and/or investigation in my opinior	n death occurred a	t the time date and	I place and due to the	cause(s) and manner stated	
	© ₹ © §		29b. Signature doe title of certifier	B, M.D.	knowledge, death occurred at the 29c. License  DCC 23a) (Type, Print)  Sinai	number 54485	2 28	Od. Date signed (Mont	h, Day, Year)	
\			30. Name ald address of person who	completed cause of death (Item)	23a) (Type, Print) Sinai	Hospita	10+	Bultimor	/~	
	Stat Registra	.C	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	. parket	/				
DEIN	/IH 17 Rev 7/20	00g	WIIII V				-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 42408 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Hubbard Month Day 28 Physician/ amos 2011 12:35P M December Medical acility Name (if not institution, give street and number) **Examiner** 4c. County of Death timore 11stoou . Date of Birth Birthplace (State or Foreign Country) Age (In yrs. last birthday, **Funeral** 1 M 2 D F Director 62 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f 1 Yes 2 No time Street and Number 10g. Citizen of What Country? 0 must be Funeral 23a items Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 0 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No 3 ₩idowed 4 Divorced "natural", Year or Dates Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
iife. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, than Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ္ Albert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, item 27 MO 21237 a 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If its any injury or of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other p 4 Donation 5 Other (Specify) 22. Name and Add Funeral Service Licenses Avenue 23a. Part 1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Lung Concer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Day the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has page 2 performed? Yes 2 No 1 🗌 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Wother Specify) 2 WNo မ 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier norrajapamen.D 00057465 12/29/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Baltimore MD N.S. Rajapakse, M.D. 5203 Smith AV 31. Date filed (Month, State

Registrar

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 29 **Physician** CURTIS HOWAR 10:09 A M 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, DEC 5 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 577-94-8554 50 Yrs. 1961 WASHINGTON, Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Itams 23s or 28e-1 show the Medical Example must be notified at LANDOVER 1X Yes 2 No Director MD PRINCE GEORGE'S 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7016 EAST KILMER STREET 20785 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status o filed within 72 hours efter d I Hygiene. other then "natural", or Itan Black, White, etc. ☐Yes 2X No f Yes, Give 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 11TH DISPATCHER es 1 and 2 should be filed wi of Health and Mental Hygien filem 27 ie marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OCIE BEE HOWARD MARY TRAVIS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10609 MILLWOOD CHAPEL LANE, UPPER MARLBORO, MD 20772 RITA HOWARD-COOPER/ SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of H ant: If ite 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Depertment of Importent: If eny injury or once. 01/06/2012 RIVERDALE, MARYLAND RIVERDALE CREMATORY \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME Daphney 7474 LANDOVER ROAD, LANDOVER, MARYLAND 20785 23a. Part1. Ento the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physicien and for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the a 1 ☐ Yes 2 ☐ No 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 21 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 No I or Attending Physicien: after death. Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗀 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier deáth (Item 23a) (Type, Print) 30. Name and addr B V 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 5 2012 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42410 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** DONALD HENRY 5:22 PM DECEMBER 31 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 🕅 M 2 🗆 F Yrs Director 164-22-8367 07/13/1929 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at Director 1 X Yes 2 ☐ No Baltimore MD Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 1700 Holaview Road, B3 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Examiner 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: ≥ Specify: 3 Widowed 4 Divorced White Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8 <u>Self-Employed</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elva မ <u>Jackson</u> Lawrence Henry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Woods / Daughter 407 Aggies Circle, Condo L, Bel Air, MD 21014 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If It any Injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy <u>Gifts Registry</u> 01/03/2012 Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Edneral Service Licensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition a. Pneumonia resulting in death) //Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): burial-transi that initiated events and resulting in death) Last Due to (or as a consequence of): rsician Physician/Medical page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 

Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Jas performe 2 🗌 No 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 X Natural 1 Yes 2 🗌 No 2 Accident Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records. within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Hospital

21215-0036

Baltimore, Maryland

State Registrar

31. Date filed (Month, Day, Year) JAN 0 5 2012

29b. Signature and title of certifier

Dilanna Cettomai MD

4 \ Homicide

(check only

29a. Certifier

Medical

DEANNA CETTOHAI 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Darke

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-DOO

29d. Date signed (Month, Day, Year) December 31,2011

4940 Eastern Avenue, Baltimore, MD, 21224

			Please	e type or Print in i					•	bie.	
			For State	State of Marylan		artment of F tificate of L		Mental Hy	211	11 42411	
			Registrar  1. Decedent's Name (First, Middle, La	est) I i	Cer	lincate of L	Jean	2. Date of De	Reg. No.	2 Time of Double	
	Physicia Medic	cal	Clinton Willia	am Henry	1	sett,	Jr.	Month	Day	Year OIL 16 03 PM	
	Examir	ner	4a. Facility Name (if not institution, giv			Battimo	r Location of Deat	h 	4c. County of	f Death	
	Funeral Director		210 /2 5050	Sex 7. Age (In yrs. la 1 ☑ M 2 ☐ F 68	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da Sept 21	iy, Year)	9. Birthplace (State or Foreign Country) aryland	
	d iow it		Usual Residence of Decedent  10a, State  10b, County	100 City	. Town or Los	ection	<u> </u>	ocpt 21	, 15-15		
	Marylan 28a-f sh otified a	Funeral Director	MD	Balt	, Town or Loc imore	ACION				10d. Inside City Limits 1 ★ Yes 2 □ No	
	with the s 23a or ust be n	eral D	10e. Street and Number 4227 Annapolis Road			10f. Zip Code 21227			10g. Citizen of Wh. U.S.A.	nat Country?	
	death items ier m	Fun	11. Marital Status	12. Was Decedent Ever in U.S		Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No-	14. Race	- American Indian,	
36	after (I", or	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give 1963–67 Year or Dates.		Yes 2 No		5 moan, 5.6.,		White, etc. White	
9	nours natura ical E	Completed	15. Decedent's E		16a. Deced	ent's Usual Occup	pation		16b. Kind of Bus	inose/Industry	
215	n 72 h e. ian "n Medi	dmo	(Specify only highest gi		(Give k	ind of work done of NOT use retired)	during most of wo	rking	16b. Kind of Bus	iness/industry	
21	ygiene ygiene ner th t, the		11		Sales				Automobile		
Maryland 21215-0036	d be filed Mental H arked oth	To Be	17. Father's Name (First, Middle, Last) Clinton William Henry	Isett					st, Middle, Maiden Surname) aine Hamilton		
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	2	19a. Informant's Name/Relationship (1) Lola Jones girlfrie		19b. Mailin 5806 01	g Address (Street a	and Number or Ru Brooklyn Pa	ral Route Numbe rk, Maryla	er, City or Town, Sta and 21225	te, Zip Code)	
Baltimore,	permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trae		20a. Method of Disposition  1 3 Burial 2 Cremation 3 4 Donation 5 Other (Spec.	Removal from State	lace of Disposemetery, crem	sition (Name of atory or other place <b>enetery</b>	Janua	Date <b>ry4, 2</b> 012		Park, Maryland	
Balti	permit. I Departm Importa any inju		21. Signature of Fur end endo Aicen		// )				iak Funeral		
	*	Н	23a. Part 1. Enter the o sease, or com	plications that caused the death	Z3/				Maryland S	Approximate	
200	Physician/		shock, or heart failure. List only of Immediate Cause (Final		Lat T	Carren				Interval Between Onset and Death	
C	Medical		disease or condition resulting in death)	a. Due to (or as a consequence		farction	1				
	Examiner	<u>_</u>	Sequentially list conditions.	b. ————————————————————————————————————							
	sit sd	cal Examiner	Sequentially list conditions, if any, each of to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	endo orj.						
	be executed sician and burial-transit	Exal	that initiated events resulting in death) Last	c	ence of):						
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9289	ficate g phy as the	Nedi		d.							
99 ×	eath certificate k attending phys d for use as the		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan		Ectopic pregnance	ev.		23d. Date	of delivery	
Вох	deatl	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of dog ☐ Unknown		Other (specify)			Mont	h Day Year	
P.O.	iires that the dea i signed by the a id be detached f	Phy	Part II. Other significant conditions of	contributing to death but not resu	ulting in the un	iderlying cause giv	ven in Part I.	23e Did to	obacco use contrib	ute to the cause of death?	
S, F	ires the signer of the signer	Completed by						1		Probably 4 Unknown	
Records,	v require been si should	lete						24a. Was	an 24b. We	ere autopsy findings available	
3ec	Physician: The law in this certificate has been director, page 2 s	omo						autor perfo	osv pri	or to completion of cause of ath?	
alF	ian: T rtifica ctor, p		25. Was case referred to medical			26. Pla	ace of Death (Che		2 No. 1 L	Yes 2 No	
Κ	hysica nis ce Il direc	To E	examiner? 1 ☐ Yes 2 🗹 No	Hospital: 1 🗹 Inpatient 2 🗆 E	ER/Outpatient	3 DOA Othe	er: 4  Nursing H	lome 5 🗌 Resid	dence 6 🗆 Other	(Specify)	
οl	ing P	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	?	28d. Describe h	now injury occurred		
sior	l or Attendi after death. Director: A I in by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		no form atrac		Yes 2 No	006 1 41- 6	Maria de la 1841 de 1841	- Destablished	
Division of Vital	ital or Attending P us after death. ral Director: After t lled in by the funera		4  Homicide determined	building, etc. (Specify)				City or Tou	n, State)	or Rural Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 \( \subseteq \text{ Medical Exam} \)	sician: To the best of my knowle iner: On the basis of examination se Practitioner: To the best of my	and/or investig	gation, in my opinio	on, death occurred	at the time, date a	ind place, and due to	o the cause(s) and manner stated.	
	With To t	_	29b. Signature and title of certifier	/		29c. License	number		29d. Date signed (I	Month, Day, Year)	
	Mar		1 / setten Be	new		RES	-000	3	December	- 30 2011	
-	P1. M.		30. Name and address of person who defined Koner		23a) (Type, Pri	*		2 11		010-0	
	Stat	e_	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ıre	1.U 00d	Nolte St	Baltime	ore Mary	land 4281	
	Registra	r	JAN U 5 2012	12 1	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 26 DECEMBER LENORA 2011 JACKSON 8:01  $A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CENTER PRINCE GEORGE'S CHEVERLY Social Security Numbe 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Min 1 🗆 M 2 🛛 Day, 1 WASHINGTON, **Director** 578-86-8274 JÜNE 1959 Usual Residence of Decedent 28a-f shov it of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND PRINCE GEORGE'S 1 X Yes 2 No CAPITOL HEIGHTS 10e. Street and Number 10g. Citizen of What Country? Funeral 6322 CARRINGTON COURT 20743 UNITED STATES Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black. White, etc þ 1 X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: BLACK Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH POSTAL WORKER FEDERAL GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JOHN JACKSON JANETTE DINKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANETTE DINKINS / MOTHER 500 MILLWOOF DRIVE, CAPITOL HEIGHTS, MD 20743 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) RIVERDALE CREMATORY 01/07/2012 RIVERDALE, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD, HYATTSVILLE, MARYLAND 20785 Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shocks heat vailure. List only one cause on each line. 23a. Part Interval Between Onset and Death Immediate Cause (Final Physician/ ATAL disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events the burial-transit Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Year Month Pregnant at time of death Day the 9 Unknown g Unknow Division of Vital Records, P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performe this certificate Yes 2 1 🗌 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Tes မ 1 Inpatient 2 PR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Anatural 5 Pending injury within 24 hours after death.

To the Funeral Director: A completed filled in by the fu М 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature title of certifier

Registrar DHMH 17 Rev 7/2009

State

30. Mame and address of person

GRIFFIN DAVIS

31. Date filed (Month, Day,

HOSPITAL DRIVE CHEVERLY

o completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

3001

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Year Tackeron 5-45 PM bru 30 2011 /Medical 4a. Facility Name (If not institution, give street and number) Ekaminer 4b. City, Town, or Location of Death 4c. County of Death Baltimac Samuelan If Under 1 Year | If Under 24 Hrs. Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 247-36-4803 1 M 2 □ F SOUTH CAROLINA **Director** 07-05-1927 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show id other than "natural", or items 23a or 28a-f show event, the findical Experience must be notified at MD Director BAUTIMORE 1⊠Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1604 SHERWOOD AVENUE 21239 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Mayes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No 2 Specify. Specify: BLACK 3 ⅓ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene. 7 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL EMPLOYEE MAIL CARRIER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MOSES JACKSON WILLIE MAE JOHNSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 1604 SHERWOOD AVE. BANTIMORE, MD. 21239 ANN JOHNSON (DAUghter SHIRLEY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State CEDAR HILL CEMETERY 1/7/2012 BAUTIMORE, IND 4 Donation 5 Dother (Specify) 21. Signature of Funero Service Licensee 22. Name and Address of Facility VAUGHN GREENE FUNDIAL SCVS Vayo ROAD. YORK 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final assdial **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physiclan: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ◯ No has autopsy perform certificate 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 X Natural 2 ☐ Accident 5 | Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 24 hours after deatle Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D71796 MD MARCEDU MARCEDU JYOTSINA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

IAN 0 5 2012

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Rawan

Baltimae MD 21239

Samoular Hospital

32. Registrar's Signature

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

State 31. Date filed (Month, Day, Year IAN 0 5 201

**ORIGINAL** 

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ P Medical MOI acility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death timore 8. Date of Birth (Month, Day, **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) **Director** 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland must be notified at Director 28a-f 1XYes 2 ☐ No 5 10e. Street and Number 10g. Citizen of What Country? 23a Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sachelor Degree Be 18. Mother's Name (First, Middle, Maiden Surname) ပ Kelle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numb Rural Route Number, City or Town, State, Zip Code) Baltimore Celle 6308 other ietta MO 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 2012 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MM 22. Name and Address of Facility March F/H East Hol Signature of Funeral 5 rvice Licensee fa Mike Jan Bulton 21202 MA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) HOUTE MYOCARDIAL INTARCTION Medical Due to (or as a consequence of) Examiner ATHEROSCLEPOTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE ves, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the sale 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has i autopsy perform this certificate 2 🗌 No ☐ Yes Yes 24 hours after death.

• Funeral Director: After this certifics letely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) ္ဝ 1 Yes 2 🗌 No ER Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 3 🗀 To the within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH MID. 5601 LOCH BALTIMORE, MD 21237 PAVEN BUYD 31. Date filed (Month, Day, Year)

JAN 0 5 2012 State 32. Registrar's Signat Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 7:07 P M 2. Date of Death Physician/ Gladys Agnes Kankosky 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 204-28-1585 76 **Director** 1 M 2 F Pennsylvania 4/07/1935 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Aberdeen 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 810 Maxa Road 21001 USA item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. 0.10 Black, White, etc. 1 Never Married 2 XMarried by Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify. permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar Completed If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Baker Baking 12 0 2011 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Warren Russell Nye Bessie Ellen Lutz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Kankosky,Jr./Husbahd 810 Maxa Rd, Aberdeen, MD 21001 DECEMBER 20c. Location - City or Town, State West Chester, 20a. Method of Disposition 20b. Place of Disposition (Name of Date West Chester Pennsylvania cemetery, crematory or other pla 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ferris & Co. 12/30/2011 5 Other (Specify) 4 Donation 21. Signature 22. Name and Address of Facility Tarring-Cargo Funeral Home, 333 S. Parke St., Aberdeen, Ď <u>21001</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ CONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Due to (or as a consequence of): Examir Cause (Disease or injury that initiated events the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 ate has been signed by the attending page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopu, performed: Yes 2 **X** No After this certificate 1 Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: မ 1 Yes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 4 Nursing Home 5 Residence 6 N Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending injury 2 🗌 No 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title o 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) JAN 05 Registrar

DHMH 17 Rev 06-2011

GLADYS KANKOSKY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death acility Name (if not institution, give street and number) **Examiner** 8. Date of Birth 9. Birthplace (State or Foreign If Und **Funeral** 1 🗆 M 2 🔽 F Months Hours Min. Yrs Director 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 1 Yes 2 No Itim 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Number Funeral items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Examiner Armed Forces? Black, White, etc. o, Completed by 1 Dever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify "natural" 3 ₩idowed 4 Divorced er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DONOT use retired) /Seconday (0-12) College (1-4 or 5+) DECK and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1046. 2 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau St. Method of Disposition 20b. Place of Disposition (Name of Date 1 W Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 23a. Part z Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final 21. Signat Home Approximate Interval Between Onset and Death Immediate Cause (Final Failure To Thorne hysician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CHF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): CO PD the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 🗌 Yes 2 No certificate Yes 2 director, To Be 25. Was case referred of medical 26. Place of Death (Check only one) 2 🗹 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manne of Death 28b. Time of Medical Certificate: 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred injury 5 Pending 1 Natural 2 No Accident 24 hours after death. Funeral Director: A Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 2012

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signat

D72536

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOHN JOSEPH MOONEY, JR. DEC 2011 8:00P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE COUNTY 5629 NORTH LANE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Feb. 9, 1923 216-16-3731
Usual Residence of Decedent 1 🗙 M 2 🗆 F **Director** Maryĺand 88 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Baltimore County Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21206 USA or items 23a 5629 North Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 Married 1 X Yes þ 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White "natural", Year or Dates. WW11 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 2 should be filed with h and Mental Hygien 7 is marked other th <u>lectrical Construction</u> Baltimore County N/A 10 vrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margaret Anseln Carr John Joseph Mooney, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2507 Taylor Avenue Baltimore, Md. 21234 19a. Informant's Name/Relationship (Type, Print) Michael Fitch (Nephew) Important: If item 27 any injury or other tra 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date of 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other 1-5-2012 Gardens of Faith Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 e of Funeral Service Licensee or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Phylican Offronio Obstructul 4RD disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examin Unact burial nding physician ause as the burial Physician/Medical that the death certificate be Box 68760 IE FEMALE use es, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death ed by the a detached f ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | þ 1 Yes 2 No 3 Probably 4 Onknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No costno 24a. Was an page 2 s autopsy Cesponse; uningry Retention with induellus certificate Yes 2 No Division of Vital 25. W case referred to medical e of Deat heck only one) Hospital or Attending Physician: funeral director, Be examiner? Hospital: Other: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 \(\sum \) Yes Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director After to completely filled in by the funeral com injury 1 Natural 5 Pending 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 20027693 person who completed cause of death (Item 23a) (Type, Print) Name and address of 530 Walther Que Boltimore Md2 State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner LMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours 1**⅓**M 2□ F Director Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Experient must be notified at 1ÆYes 2☐No MORE Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. BLACK ģ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be in ment of Health and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) t of Health a 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 Other (Specify) 2 Brandlure of Funeral Service Licensee Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed use as the burial-transi and Due to (or as a consequence of) P,O. Box 68760 ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐Yes 2 ☐No 1 □ Yes 2 □ No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Symbol Nursing Home 6 Other (Specify) Hospital: 1∐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 27. Manner of Jeath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural

Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi th (Item 3a) (Type, Print) 940 W. BACTIMONEST. SA Name and address of person who completed won

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 30M Clara Joanne McDanie] lecembe Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Month Hours (Month, Day, Year) **Director** 215-26-8580 1 M 2 X F Yrs. 79 07/24/1932 Pennsylvania permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Imprortant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he marked once. 10b. County Director 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MD Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 308 Sunbrook Lane U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces þ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 X No 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced Specify: Year or Dates White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) <u>Executive Secretary</u> Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Otho Brown Scott Anita Jamison Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Roane / Daughter 10814 Antiqua Terrace, #103, Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 01/03/2012 Anatomy Gifts Registry Hanover, Maryland Signature of Juneral Service Linensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ SEP TIC disease or condition resulting in death) SHOUL Medical Due to (or as a consequence of): **Examiner** RINARY Sequentially list conditions, Examine if any, leading to I inneutate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of DIARRHEA or Attending Physician: The law requires that the death certificate be execut the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 as attending | for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 menths?

1 Yes 2 No Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death detached 9 Unknown 9 Unknown sate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 After this certificate 2 No 1 🗌 Yes ours after death.

eral Director: After this certifica
filled in by the funeral director, 1 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural Natural injury 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital within 24 hours a

To the Funeral Completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

2 State

2AMESH 31. Date filed (Month, Day, Year) 5 2012 JAN ()

29b. Signature and title of certifie

only one)

1116 Medical Campus Rd., Hagerstown, MD 21742 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KUMAR

Registrar

29c. License number

D70607

29d. Date signed (Month, Day, Year)

12

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			E. III	Pleas amend	se Type or Pritem 17 per Stale of M Item 25 per 1 Per PHY G	nt in I	Black II	ndelible In	<b>k. Ensure</b> Health and	All Copie Mental Hy	s Are	Legible	•
		•	State RegistrarMe	Amend : nd #1&3	Item 25 per 1 Per PHY G	dr., 925 3	37094 <del>2</del>	01/05/201 11/203 <b>19</b> of	Death		Reg. No.	201	42421
	Physicia Medi		1. Decedent's Name	e (First, Middle,	Mc Dona	1	Chevi		cDonald	2. Date of De Month	ath Day	5 2011	3. Time of Death
0	Exami		4a. Facility Name (if	not institution,	give street and number)	7	Center		or Location of Deat	,		County of Dea	th Arundel
	Funeral Director		5. Social Security Nu 212-70-4	ımber (			ast birthday)  Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th 14 166/5	9. Bir	thplace (State or Foreign
	_		Usual Residence of				v. Town or Lo	cation		100,00	,		10d. Inside City Limits
	Marylar 18a-fst tified	recto			Arundel	roc. Oits	,	en Burn	ie				1 Yes 2x No
	ith the 23a or 2st be no	Funeral Director	10e. Street and Num		D.d.	!		10f. Zip Code			_	zen of What Co	ountry?
	eath w	Fune	11. Marital Status	Ollaiu	12. Was Decedent	Ever in U.S	S. 13. \	21060 Was Decedent of H	Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or No-		S.A.	erican Indian,
9800	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by	1 😾 Never Marrio 3 □ Widowed 4		Armed Forces?  1 Yes 2 If Yes, Give Year or Dates.	<b>₹</b> No		f Yes, specify Cub		to Rican, etc.)		Black, Whit	e, etc. lack
21215-0036	72 hou n "natu Aedical	nplet			's Education t grade completed)		(Give	dent's Usual Occup kind of work done O NOT use retired	during most of wo	rking	16b. Kii	nd of Business	Industry
	within /giene.	e Cor	Elementary/Seco 12th Gr	ade	College (1-4 or	5+)		pentry	,		Self Employed		
Maryland	be filed ental Hy ked ott	To Be	17. Father's Name (F Edward		cager - Cager					me <i>(First, Middl</i> e, uanita		,	
aryl	and Me is mar		19a. Informant's Nar				19b. Mailir	ng Address (Street	and Number or Ru				p Code)
	of Health of Health of Item 27 i				nald Jr.(s				d Rd.,	Glen Bu			
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or oth		20a. Method of Dispo 1 Burial 2 Donation	☐ Cremation 3	Removal from State	CE	emetery, cren	sition (Name of natory or other pla nurch C	em. 12/	31/11		cation - City or n Burr	Town, State
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Fun	neral Service Lic	ensee	Con	no 3	osephadh 140 N.	sof <b>Br</b> own Fulton	Jr. Fi	uner Balt	al Hor	me PA , MD21217
		8	23a. Part 1. Enter the shock, or heart	ne disease, or c t failure. List onl	omplications that caused by one cause or each line	the death							Approximate Interval Between
	Physician/ Medical		Immediate Cause (F disease or condition resulting in death)		a. Seps/ Due tylor as	S conseque	ence of						Onset and Death
	Examiner	je l	Sequentially list con	nditions,	b								
	uted d ansit	Examiner	if any, leading to impose the cause. Enter Underloads (Disease on it that initiated events	lying	Due to (or as	a consequ	ence of):						
,	be executed ician and burial-transit	انتا											
68760	ficate I g phys as the	Medic	IE EELAN E		d								
. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	Ideath 3	Ectopic pregnan Other (specify)	су		2	23d. Date of de Month	elivery Day Year
ls, P.O.	uires that the signed by the signed by the detail	<u>م</u>	Part II. Other signific	cant conditions	s contributing to death b	ut not resu	ulting in the u	nderlying cause gi	ven in Part I.				o the cause of death?
of Vital Records,	The law require ate has been si page 2 should	Completed								24a. Was auto perfo	psy ormed?	prior to	ntopsy findings available completion of cause of
tal F	i <b>cian:</b> The certificate 'ector, pag		25. Was case referred examiner?	d to medical				26. P	lace of Death (Che		2XLNo	l 1 ∐ Ye:	s 2 No
f Vii	Physic this ce al dire	은	1 Yes 2X	No	Hospital: 1 Inpati		ER/Outpatien		4 ☐ Nursing F	Home 5 Resid			cify)
0	ding h. After fune	Certificate:	1 Natural 2 Accident	5 Pending	(Month, Day	, Year)	injury	worl	njury at vork?				
Division	e Hospital or Atten 24 hours after deat 9 Funeral Director: leted filled in by the	al Certii	3 ☐ Suicide 4 ☐ Homicide	6 U Could no determine		iry - At hor :. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tow		Number or Ru	ral Route Number,
)	To the Hospital or within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2 L	Medical Exa	hysician: To the best of aminer: On the basis of e	kamination.	and/or invest	igation in my opini	on death occurred	at the time date a	and place	and due to the	cause(s) and manner stated
	To the within the complete com		29b. Signature and		There.	Mi	D.	29c. Licens	e number		20d Date	signed (Mant	h Day Voorl
			30 Name and addres	/ / / .	o completed cause of d	eath (Item :	23a) (Type, P	rint)	10 (1.	$\mathcal{R}$	اعران	MID	-25,2011 21061 <del>20815</del>
	Stat Registra		31. Date filed (Month,	010	32. Registra	r's Signatu	100/2	L Drie	9/6	n our	nie,	July 1	20015

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 25 per me 8923 1-5-12 of Health and Mental Hygiene For State Registrar 42422 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 32 AM dward December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hopkins Baltimore Hospita The Johns 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 14, 1975 215-82-1117 36 Maryland **Director** 1 🗶 M 2 🗆 F Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland at Director items 23a or 28a-f s ner must be notified MD Baltimore 1X Yes 2 □ No Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7301 Dunbrook Court Apt. A 21222 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, ı "natural", or item edical Examiner n Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic mercia. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Analytical Chemist BioTech Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Christine Manes Edward William Ott Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Ott (Mother) 5114 Doubs Road, Adamstown, Maryland 21710 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place)
Smithsburg Crematory 1 Burial 2 Kremation 3 Removal from State 12/14/2011 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Reeney & Basford P.A. Funeral Home 106 E. Church St., Frederick, MD 21701 any inj once, 21. Signature of Funeral Service Licensee MO1612 106 E. Church St., Frederic Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Annroximate Interval Between Onset and Death Immediate Cause (Final -10 LLAK Physician/ Hemorrhae Intraventricular disease or condition resulting in death) Medical **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Mon Examine Due to (or as a consequence of) burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) signed by the at Id be detached for g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown or Attending Physician: The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 X Yes 욘 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funeral 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ 29d Date signed (Month, Day, Year, 29b. Signature and title of certifier 20c. License number RES -000 December 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe St Baltimore Haryland 21287 31. Date filed (Month State 5 20

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 2029 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 29, 2011 Physician/ Polissedjian Marie Azni Medical 12 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville 29 If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Min Hours 128-34-5690 **Director** 1 □ M 2 🗓 F 86 March 15, 1925 France Usual Residence of Decedent or 28a-f shov notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Gaithersburg MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o edical Examiner must be Funeral 20877 101 Odendhal Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married 5-0036 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed POLISSED JIAN the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other tany injury or other traumatic event, th once. Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Siranouch Kendjoyan Toros Djizmedjian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18028 Mill Creek Dr. Derwood, MD Andre Polissedjian - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Greenburgh, NY 1 - 5 - 124 Donation 5 Other (Specify) Ferncliff Cemetery 21. Signature of Funeral Service Licen: 22. Name and Address of Facility Edwards-Dowdle Funeral Home 64 Ashford Ave. Dobbs Ferry, NY MOIZEH 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5 udden Physician cardiac death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner artem atherosclerotic coronan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or injury that initiated events resulting in death) Last the burial-tra and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month 5 Other (specify) Pregnant at time of death s been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? 1 Yes 2 No certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Hospital: 1 Yes 2 No 1 Inpatient 2 KER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: iniury 1 Matural 5 Pending Accident 24 hours after death. Funeral Director: At Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

3. Time of Death

1X Yes 2 ☐ No

Year

29d. Date signed (Month, Day, Year)

2029

December 29,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Conter Drive, Rockiville, manufant 20850 Medica wenk, MD 2901 Jonathan 32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 0 5 2012 Registrar

within 24 hou

To the Fune

completely fi

Medical

29a. Certifier

only one)

3 🗆

ure and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:32 AM Betty Shepherd Pokrzywa December 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore Social Security Number 9. Birthplace (State or Foreign Country) Chicago, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours 220-12-4398 Director 1 🗆 M 2 🗶 F 89 Nov. 01, 1922 Illinois Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1803 Larkin Pl. U.S.A. 21015 iral", or items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White "natural" 3 🔀 Widowed 4 🗆 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b, Kind of Business/Industry than, Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Advertising Account Executive 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important if item 27 is marked any injury or other traumations. ည Robert Pokrzywa Bessie Monahan 24, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Pokrzywa (Son) 1803 Larkin Pl. Bel Air, Maryland 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Evans Funeral Chapel
Bel Air 1 Burial 2 X Cremation 3 Removal from State 28, 4 Donation 5 Other (Specify) Forest Hill, Maryland 22. Name and Address of Facility.
Evans Funeral Chapel & Chemation Services
3 Newport Dr. Forest Hill, Maryland 21050 Funeral Service Licenses Frey R. Testermen

(M) R (M)01543) 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Ph si i n disease or condition CONGESTIVE HEART FAILURE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or se a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 🗶 No eral Director. After this certificate has been signed by the atte filled in by the funeral director, page 2 should be detached for Month Day Year 1 Li tes 2 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed Yes 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: 2 **X** No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work? 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and Mile 201 of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State JAN 0 5 201 Registrar

DHMH 17 Rev 06-2011

DECEMBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month NOVEMBER RYBACKI MILDRED 2011 Medical 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death **Examiner** RALTIMORE HARBOR HOSPITAL TIMORE 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) **Director** 218-20-1817 Feb 28, 1927 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland event, the Medical Examiner must be notified at Director 1 Yes XXX No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō Funeral 23a 6403 Grafton Garth 21061 USA items ? 72 hours after death 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 'natural", or þ 1 Never Married 2 Married 1 ☐ Yes XXX No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2XX No Specify: Completed 3 XXWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Beautician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Selby Lottie Mae Janish and 2 should the Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Helen Selby 20a. Method of Disposition Sister 6403 Grafton Garth, Glen Burnie, MD 21061 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2XX Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Veterans Cem | Dec 1, 2011 Crownsville, MD 21. Sign perc of Funeral Service Light see 22. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy S., Glen Burnie, MD 21061 23a. Part 1. Enter the diseas shock, or heart failure. MO1148 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ rebrai disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner TIFICATION APPROVED BY MEDICAL EXAMINER if any, leading to immedia cause. Enter Underlying death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of) attending physician Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No ō Month Pregnant at time of death Dav Year P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? <u>چ</u> dementia Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 ☑ N this certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 XYes 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After it 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar

3

31. Date filed (Month, Day, Year) JAN 0 4 2012

29b, Signature and title of certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year) NOVEMBER 26 201

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SENAYET AGONAFER 3001 SOUTH HANOVERST BALTIMORE MD 21225

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23aPtII,25 per me. 2923,01/03/2012dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Y CLIVETORD KO11 1:00 Zoil Medical 4a. Facility Name (if not institution, give street and number, 4b. City Town, or Location of Death 4c. County of Death Examiner GEVEY GINT CECIL MOVES COME SYS 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Dec. 23 Year)1946 Pennsylvania 1 JM 2 JF 64 Yrs. **Director** 192-36-7947 Usual Residence of Decedent 28a-f show 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1117 Oakwood Lane 21015 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married by 1 Types 2 No If Yes, Give Year or Dates. 166 1 ☐ Yes 2 ☐xNo Specify: Specify: Completed 3 Widowed 4 Divorced White '67 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic names \*\*---\* Nuclear Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Dorothy Cheslin Aaron Roth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Roth / Wife 1117 Oakwood Lane, Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Metro Crematory Inc. 11/19/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K 22. Name and Address of Facility Cremation Society of Maryland Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METROS MARC disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAM! Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIANERS MELLITUS 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Calomany ANTENY DISCUSE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy perform nis certificate h NON-INGALING WXWW due to Diabetes 007 2 🗆 No 1 Yes Mellitus 25. Was case referred to medical Be Place of Death (Check only one) examiner? 1 X Yes 2 110 Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Aursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Baltimore, Maryland 21215-0036 Physician Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Certificate: 24 hours after deat Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and mainer as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated and place are due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and ti 20390 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GANT POINT VA SUDG. 23 Rum 229 HORICES HOESCH Registrar's Signature Registrar DHMH 17 Rev 7/2009 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death December 29, 2011 Physician/ 9:25 Рм Satterwhite Redd Doris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Lorien Nursing & Rehab Center Columbia 9. Birthplace (State or Foreign . Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Aug. 15, Year 1920 Days Hours North Carolina 1 M 2 X F 240-60-2950 91 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 ∑ Yes 2 ☐ No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21044 6334 Cedar Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher permit. Page 1 and 2 should be filed witl Department of Health and Mental Hygien Important: If item 27 is marked other I any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marianna Cutts Clyde G. Satterwhite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2156 Golf Course Dr., Reston, VA 20191 Anne Taylor (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place)
Science Care 1/2/2012 Aurora, CO 21, Signature of Juneral Service Licen Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 una 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 4 d disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Examir and that initiated events resulting in death) Last Due to (or as a consequence of) ng physician a Physician/Medical Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 1 ☐ Yes ∠ ■ 9 ☐ Unknown Unknown P.O. signed by significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has performed? death? 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 2 🕅 No ER/Outpatient 3 DOA မ 1 Inpatient 2 I within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

29b. Signatur and title of certifier

100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Kd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 24, Sadie Mullins Sexton 2011 9:05 PM December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ft. Washington Ft. Washington Health & Rehab Prince George's 8. Date of Birth (Month, Day, You Sept 27, 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🖵 F Days Year 1909 Director 579-96-0241 102 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7504 Cardinal Lane 20744 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 XNO Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Solomon Mullins Matilda Wyatt Belcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emily Buck - Daughter 7504 Cardinal Lane Ft. Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Woodlawn Mem. Park 12 - 30 - 11Bluewell, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign Funeral Service Licenses 22. Name and Address of Facility Cravens-Shires Funeral Home 3431 Coal heritage Rd. Bluefield, WV Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotic Cardio Vascular Disease disease or condition 10 years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to imm significance. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending abusined and physician and the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 attending pt IF FEMALE res, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnate at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has a in by the funeral director, page 2 a autopsy performed' 1 ☐ Yes 2 No 1 Yes 2 No filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🙀 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-27-2011 D45365

Registrar

State

32. Registrar's Signature

11701 Livingston Road, #101, Ft. Washington, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael G. Sidarous, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend Item 25 per me, g923,01/03/12012012011 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DANIEL COURTNEY SANGER TOVEMBER Medical 1.31P 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreig (Month, Day, Year) 9. Washington, DC 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Hours Min 1**3€36**M 2 □ F Days **Director** Yrs. 215-46-4517 55 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location Director notified 1 Yes 2 No Maryland Washington Rohrersville ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be r Funeral 4404 Main Street 21779 U.S.A. items ? permit, Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2x Married Yes 21 TNO Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2XXNo Specify: 3 🗌 Widowed 4 🗌 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Computer Tech Computers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Harry J. Sanger Phyllis Gimmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Sanger/Mother 622 Washington Ave. Colonial Beach, VA 22443 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 11/9/2011 Brentwood, MD 21. Signature of Funeral Service I 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg RD. Brentwood, MD 20722 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of Examiner DAMAGE MONTHS ANOXIC RAIN Sequentially list conditions, if any leading to immediate cause. Enter Underlying ICATION APPROVED BY MEDICAL EXAMINER Exami Cause (Disease or iinjury that initiated events nding physician and ise as the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? thin 24 hours after deam.

of the Funeral Director: After this of the funeral director is the funeral director. 1 X Yes Other: မှ 1 XInpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in the operation, such as the state and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within To the title of certifier 00062223 address of parson who completed cause of death (Item 23a) (Type, Print)
EEN BILARUM, MD 196 TODRIVE, PREDERICK, MD 21702

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 28<sup>Day</sup> DEC ALICE VIRGINIA STOVER 2011 5:00A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HAMPTON MEADOWS ASSISTED LIVING TOWSON If Under 1 Year If Under 24 Hrs Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Days Mar. 18, 1922 Hours Marvland Director 1 🗆 M 2 🗶 F 89 214-16-8624 Yrs. Lisual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore City BaltimoreCity XX Yes 2 No 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral USA 21206 3911 E. Northern Parkway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X XNo Specify If Yes Give White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 I n and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Hutzler's Dept. Store 7th grade N/A Gift Wrapper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Deal Arthur White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3911 E. Northern Parkway Baltimore, Md. 21206 permit. Page 1 and 2 st.
Department of Health ar
Important: If item 27 is
any injury or other trau George Stover (Son) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 12-31-2011 Baltimore, Md. Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility lig at re of Funeral Service Licensee Lassahn Funeral Home 21236 Baltimore, Maryland 7401 Belair Rd. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final END Onset and Death DEMENTIA Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Directo for as a consequence off cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last burial /Medical IF FEMALE use Physician/ 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 5 Other (specify) g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 Jas autopsy perform within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28b. Time of 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28d Describe how injury 1X Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 00065145 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven Blvd Registrar

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Frances 2011 9:00 AMM Sweeney Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1915 Oak Lodge Road Catonsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2X F Months 08471594930 216-30-1360 81 **Director** Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 Yes 2 X No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1915 Oak Lodge Road 21228 United States items 2 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian event, the Medical Examiner Black, White, etc. ō 1 Never Married 2 Married þ 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No "natural", Specify Completed 3X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 l and Mental Hyglene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Cummings Marie Lacy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health ar Important: If item 27 is any Injury or other trau Mary Frances Frande / Daughter 2986 Hearthstone Road Ellicott City, Maryland 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) New Cathedral Cemetery 1/04/2012 Baltimore, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility David J. Weber Funeral Homes PA 311 Edmondson Avenue Baltimore, Maryland 21229 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure List only one cause Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 🗌 Yes 2 **N**o 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Sesidence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes within 24 hours after death. To the Funeral Director; After 28d. Describe how injury occurred 1 Alatural 5 Pending injury 2 🗌 No ☐ Accident Investigation filled in by the Suicide
Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Medical Priffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practionar: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) se of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 2 Day HOMASINE 0731 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL HOSPICE OF THE CHESAPEAKE HARWOOD Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Hours Min (Month, Day, Year) **Director** 579-52-0921 1 M 2 F 70 JUNE 16. 1941 WASHINGTON, DC Usual Residence of Decedent 28a-f show 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND PRINCE GEORGE'S SUITLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5477 MORRIS AVENUE 20746 UNITED STATES death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: BLACK Completed 3 Widowed 4 X Divorced the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) 12TH NUTRITION SUPERVISOR N.I.H. Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) of Health and Mental H ပ THOMAS FULTON BERTIE WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5617 WALKER MILL ROAD, CAPITOL HEIGHTS, MD 20743 TONYA NEWSOME / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State WASHINGTON NATIONAL CEM. 1/4/2012 SUITLAND, MARYLAND 4 Donation 5 Other (Specify) JB JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licenses 22. Name and Address of Facility 20 7474 LANDOVER ROAD, HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the of shock, or heart falls Immediate Cause (Finar disease or condition the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art fallure. List only one cause on each line. Approximate Interval Betweer Onset and Death Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or in that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 1 Yes 2 No Yes To the Hospital or Attending Physician: upletely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 6 Other Specify Hospital 2- No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury 1 Natural 5 Pending s after death. 2 Accident
3 Suicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Qate signed (Month, Day, Year) wher 27 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EFENSE HWY HON APOLIS 445 21401 HAF Day, Year) 5 2012 31. Date filed (Month, 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Donald J. Savoy Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)Unk 7. Age (In yrs. last birthday) **Funeral** Months Days Hours (Month, Day, Year) 219-30-4038
Usual Residence of Deceden **Director** 1 🗓 M 2 □ F 77 Oct 20, 1934 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 21206 4001 Echo Ave. USA 12. Was Decedent Ever in U.S. Armed Forces? **unk** 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 14. Race - American Indian Black, White, etc. ò ģ 1 Never Married 2 Married black 1 Tes 2 No Specify: If Yes, Give Year or Dates "natural", 3 🗌 Widowed 4 🗆 Divorced Completed 16a. Decedent's Usual Occupation unk 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other? Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unkည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Cyrus Burgess - grandson injury or other Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)  $4 \square$  Donation  $5 \cancel{X}$  Other (Specify) in state State Anatomy Board 21. Signature of Funeral Service Lisenson and P. Wade, 22. Name and Address of Facility Director 655 W. Baltimore St; Baltimore, MD 21201 t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, och a failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 5 Other (specify) Pregnant at time of death detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe this certificate 2 🗌 No 1 Yes filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 101 Other: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne eath Certificate: 28a. Date of injury (Month, Day, Year) s after death. 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined thin 24 hours at the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cartifying Nurse Practitioner To the best of my knowledge of oil than flows 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number December 29, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 J 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 08: 34 AM Spicer 2011 DEC 29 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Maryland Medical Center Balimore of 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** 6475 (Month, Day, Year) Min **Director** mo or 28a-f shov 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Yes 2 ☐ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a i may injury or other traumatic event, the Medical Examiner must he once. 21215 Ellamont USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 2 Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Be Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Church OPICER Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, Zip Code) Balto MD d/215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, by heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician. Acute disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospita∥ or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) within 24 hours after death.

To the Funeral Director After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for a in the past 12 months? Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No Hospital Other: 1 🗌 Yes မြ 1 PInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1  $\square$  Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Pec 29, 2011 1396063319 Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21201 Yousef South 22 Zarbalian 31. Date filed (Month, Day, Year) State Registrar

Registrar

Berber

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2

State of Maryland / Department of Health and Mental Hygiene 2 U for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 546 Hia December 31 2011 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltinnove Hopkins Hospita If Under 1 Year . Age (In yrs. last birthday) 4 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min Director 68 Show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits notified at Director 28a-f 1 
✓ Yes 2 
☐ No more ō 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be r Funeral items ; be filed within 72 hours after death Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates 'natural", Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working of Health and Mental Hygiene. fitem 27 is marked other than other traumatic event, the Me nited Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ۴ am 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or ural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other tractore. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sign 1 e of Funeral Service Licensee BA 66. MD 21216 North 23a. Part f. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, i i n SEOSIS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner EUKlmia Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): B. burial-transit Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown ó Month Day Year signed by the aid be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I autopsy performe death? certificate Yes funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 1 No ည 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific -000 and address of person who completed cause of death (Item 23a) (Type, Print) sta-Mario Street 600 North Wolfe 31. Date filed (Mor Registrar's Signaty State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical December Examiner stitution, give street and number 4b. City, Town, or Location of Death 4c. County of Death of Baltimore Hospital Sinai Baltimore City Social Security Numbe **Funeral** 6. Sex 7. Age (In vrs. last birthday If Unde 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Director Min 1 M 2 F Country Usual Residence of Decedent 93 28a-f show at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits notified 1 des 2 No 0 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a items . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 1. Marital Status 12 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) injury or other traumatic event, the Medical Examiner 14. Race - American Indian . Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ō þ 1 Never Married 2 Married Black, White, etc. 21215-0036 1 Yes 2 No "natural" 3 Widowed 4 Divorced Specify Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important; If item 27 is marked other than "any injury or other traumatic event, the Mes life. DO NOT use retired) econdary (0-12) College (1-4 or 5+) Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) Patient Knavn 18. Moth ner's Name (First, Middle, Maiden Surname) ည 90 15 mi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rutal Jour Number, City or Town, State, Zip Code) Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery crematory or other 4 Donation 5 Other (Specify) VVODELLA of Funeral Service Licensee 21. Signa re Baltone, Mo 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Chronic Kidney Disease Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner and Hypertenire Cause (Disease or injury that initiated events resulting in death) Last iubehi Nechrocathy Unknown for use as the burial-tran Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Èctopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Dav Year 1 Yes 2 L 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 No ☐ Yes 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 🗌 Yes Other: 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident 2 🗆 No Investigation within 24 hours after deat To the Funeral Director. Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 A Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certif 2 29d. Date signed (Month, Day, Year) December 27,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D M.D. Sinai Morpita 31. Date filed (Month, Day,

DHMH 17 Rev 06-2011

State

Registrar

Year,

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July

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Irene Washington Physician/ Month 12 2011 1:00 Medical 4a. Facility Name (if not institution, give street and number)
4012 RidgeCroft Road 4b. City, Town, or Location of Death Baltimore Examiner 4c. County of Death 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours 1 🗆 M 2 🗶 F 40-829 Director Yrs. Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If ifew 272 is marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural", or items 23a or 28a-f sho important: If item 27 is marked outher than "natural" or items 25a or 28a-f sho in injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No HIMORE 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 2/204 Was Deceue. Armed Forces? Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 🗷 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) ccountan Be 17. Father's Name (First, Middle, Last) 2 tarris Sister-In-19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Rd. 4012 21206 Kida 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore, 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Pervice Licensee March East 22. Name and Address of Facility 1101 E. North Avenue Balto, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ One ung disease or condition Medical resulting in death) Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 monthe?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After ✓ Natural 5  $\square$  Pending 1 🗌 Yes 2 🗌 No Accident Investigation within 24 hours after death To the Funeral Director: 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

ne and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signat

5 201

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lyssa Kelly Wi	nelai	State 1- For State Registrar	e of Maryland		rtment of tificate of		and	Menta	al Hygi		eg. No. 2	01		4243
Physici		Decedent's Name (First, Middle,La	,						- 1 1	Date of Deat	h Day Y	ear ear	1	Time of Death
ledical Exam	lner	Alyssa Kelly  4a. Facility Name (if not institution, gi			1.4	b. City, To	un orle	estion of		December	27, 2011 4c. Count			1653 hrs
		127 Fallston Meadow Co			"	Fallsto		Callon or	Death		Harfor		uı	
Funeral		Social Security Number 6. 8	Sex 7. Age	(In yrs. le	est birthday)	If Under	1 Year	If Under :	24Hrs. 8	. Dete of Birt	h(MM/DD/YX	YY) 9. Bi	irthpla	ace (State or
Director		212–37–1691	_M 2XF		19 yrs.	Months	Days	Hours	0.4im		5, <del>1992</del>	Fore	ıgn	Baltimore Maryland
		Usual Residence of Decedent												
0W App.		10a. State 10b. County	rd br	• .	Town or Location	on								d. Inside City Limits Yes 2 X No
Aaryland 28a-f show	ctor	Maryland Harfor	.u	per	AII	10f. Zip C	odo			110	ng. Citizen of V	Mhat Ca		
th the Maryland 23a or 28a-f sho	Director	206 Drexel Dr.				2101					U.S.A.	Wilat Coc	uniti y	
with the second		11. Marital Status	12. Was Decedent	Ever in U.S	S. 13. Was			nic Origin	n? (Specif	fy Yes or No-		ce - Ame	rican	Indian, Black,
death or iten	Funeral	1 X Never Married 2 Marrie	d Armed Forces?	X <sub>No</sub>	If Ye	s, specify	Cuban, N	/lexican, P	uerto Ric	an, etc.)		nite, etc.		
s after	by F		d If Yes, Give Year or Dates:			Yes 2						y: Wh		
hours natur		15. Decedent's Education (Specify of Elementary/Secondary (0-12)	only highest grade com College (1-4 or 5		16a. Decedent during mo	s Usual O					16b. Kind of	Business	/Indu	stry
hin 72 than than	Completed	12	College (1-4 of 5	T)	Sales	– Sal	.ly's	s Bea	uty s	Supply	Hygi	ene		
215-0036 be filed within 72 ntal Hygiene. riced other than '	Con	17. Father's Name (First, Middle, Las	t)				18	.Mother's	Name (Fir	rst, Middle, N	l faiden Surnar	ne)		
121 d be fi ental l arked	Be	Timothy Whelan								arris				
MD 21; nd 2 should builth and Men m 27 is mar	٩	19a. Informant's Name/Relationship ( Yvonne Harris (	Mother)								ber, City or To land 2			Code)
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Fel and Mental Hygient Department of Fel and Mental Hygient Inpertant of Fel and Mental Hygient and State and State injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition			lace of Disposit	ion (Name	of ceme	tery,		ate	20c. Locatio			n, State
Baltimore, remit. Pages I an Pepartment of Hea miportant: If itel niury or other tri		1 Burial 2 X Cremation 3 4 Donation 5 Other Specif		te Evå	ns Fune	rair (	hape	el D	ecemi 30,		Fores	+ 11	: 1 °	l, Marylan
altic mit. I partm ports		21. Signature of Funeral Service Lice		Test	Bel A	me end A	dress_p	f Facility	100	bombio	n Consti	~	ם ב	hir
		Loffey K E	Luna	(MD1	543) EV	lewport lewport	Dr.	Fores	£ Hil	I, Mary	land 210	<u>50                                    </u>	ובע	. nii
Physician /Medi_J		23a. Flait i. Exter the disease, or comfailure List only one cause on e	plications that caused to each line,	he death.	Do not enter the	e mode of	dying, su	ich as card	diac or res	spiratory arre	est, shock, or l	neart		pproximate Interval Between Onset and
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		Sequentially list conditions,		4401100 01,	,									
	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of	):									
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Sox 68760, death certificate be executed e attending physician and for use as the bunal - transit	Sal E	UNPENDED C		27 2	29a-f n	- mo	~02	2 1_0	012	Cm			+	
30, te be exe ysician a	ledical		AMENDED 23a	rFH,	2 <b>8a-f,p</b> G926,4/	$\frac{1}{20/20}$	12,V	VS 1-	<del></del>	<u>ъш</u>	Too. D.		4	
5876 rrifica ling ph	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	e or pregn		al death	3	Ectopic p	regnancy		23d. Date Month		ry Day	Year
Box 6876( e death certificate the attending phy-	Physician/M	1 Yes 2 No 9 ✔ Unknow	4 Pregnant at t	ime of dea	ath 5 Oth	er (Specify	)				(4			
che che		Part II. Other significant conditions		but not re	sulting in the ur	derlying c	ause give	en in Part	i.	23e. Did to	bacco use cor	ntribute to	o the	cause of death?
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rds v requi	Completed					•				24a. Was a				sy findings available bletion of cause of
Pecc The lav ate hay	E		-							perfor	med?	death?		2 No
in: 1	Bec	25. Was case referred to medical examiner?				26	Place of	Death (C	heck only		<u></u>			
of Vital Reing Physician: The After this certificate uneral director, page	P	1 ✓ Yes 2 No	Hospital: 1 Inpatier		ER/Outpatient		<u> </u>				Residence 6		er: Sc	ene
Division of Vital Records, at or Attending Physician: The law requires after ocean.  al Director: After this certificate has been seled in by the funeral director, page 2 should!	Ö	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injur (Month, Day,Ye	ar)	28b. Time of In			at Work?	- 1	d. Describe h k <b>nown</b>	now injury occi	urred		
risic r Atter er cea irector	licat	2 Accident Investigat	28e Place of Init			РШ				2 2 2	Street and Nur	nber or R	tural I	Route Number, City
Division of Vital Rec pital or Attending Physician: The I ours after ceath. After this certificate I teral Director. After this certificate I filled in by the funeral director, page	Certification:	4 Homicide determine	De		l:Priva				Ct	or Town, S	tate) 127 allsto	Fall n,Md	sto	on Meadow
Division  To the Hospital or Attend within 24 hours after oeath To the Funeral Director:			ian: To the best of my							to the caus	e(s) and manr	ner as sta	ated.	
To th withii To th	Medical	one) 2 Medical Examine 29b. Signature and title of certifier	and manner stated.	ination an	d/or investigatio				rred at the	e time, date :				
		295. Signature and title of Cartillar	~				icense r D.C.M.				29d. Date si			* .
	ŀ	30. Name and address of person who	completed cause of de	ath (Item :	23a)							,-		
8			Medical Examiner			Street,	Baltim	ore, MI	D 2122	3				
St Regist	ate	31. Date filed (Month, Day, Year)  JAN 0 5 2012	37. Registrar	s Signatur	bar	1								
Regist	1121	9011 0 0 2017	person	13.	1900									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Helen Louise Watkins OPM 26 201 erember Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ictuzens Nursing Havre De tar HOM arca 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (In yrs. last birthday, 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Min. Hours 9/27/1922 218-14-1191 89 Maryland Director Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UŠA 21078 415 S. Market St. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify White Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important. If item 27 is marked other than any injury or other traumatic event. The Ma Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker At Home 8 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Earl Nuttall Oela Garrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Bush Chapel Rd, Aberdeen, MD 21001 Sharon Wagg / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of <sup>20c. Location - City or Town, State</sup> West Chester, Pennsylvania Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 12/30/2011 Ferris & Co. 21. Signatur of weeps ice ree 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
333 S. Parke St, Aberdeen, MD 21001 Part 1. Enter the disease, or complications that caused the death. Do not either the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Firsten NA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or iinjury Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the bunal-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month 4 Pregnant at time of death Day Year ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes Be funeral director, 26. Place of Death (Check only one) No Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No М Accident Investigation Suicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who comp 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Cathins

DHMH 17 Rev 7/2009

ODIOBL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 07 2011 11:05 Catherine Anthony Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Spa Creek Center Annapolis . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday Days 256-16-6279 Director 1 🗆 M 2 🙀 F 09/01/1921 90 Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3906 W. Shore Drive 21037 United States death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 24 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. 3 X Widowed 4 Divorced Specify: White Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry uld be filed within re... d Mental Hygiene. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Publishing Executive Assistant marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Philip Friberg Louise LaMotte and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Peg Anthony / Daughter 3906 W. Shore Dr., Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify, Crownsville Vet. Cem! 12/13/2011 Crownsville, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part / Enter the dis-axt, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failur / List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ tastalu Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): attending physician I for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perforn death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 💢 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: After t 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? ours after death. eral Director: Aft filled in by the fur 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 🗌 Homicide determined City or Town, State) Medical 29a. Certifier 🚁 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

address of person who completed cause of death (Item 23a) (Type, Print)

Chimene L. Liburd. 2401 Brandermill Blvd., Suite 330, Gambrills, MD 21032

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D54020

29c. License number

29d. Date signed (Month, Day, Year)

12/08/2011

31. Date filed (Month, Da

29b. Signature

sistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health State AMEND#18, PER FH, QACHD, MS, 12/20/11 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 12. 2011  $\mathbf{P}^{\mathsf{M}}$ Medical JOAN F. ATWELL 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **QUEEN ANNE'S** CENTREVILLE QUEEN ANNE'S HOSPICE CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days **Director** 213-26-4371 1 🗆 M 2 🗶 F 82 DEC. 10,1929 MARYLAND 28a-f show items 23a or 28a-f sho her must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director STEVENSVILLE **OUEEN ANNE'S** 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21666 109 RIVERVIEW ROAD USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō à 1 Never Married 2 X Married 1 Yes 2 X No If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify. "natural", Completed 3 Widowed 4 Divorced Specify: WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 12 3 REGISTERED NURSE **HEALTH CARE** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH DULONG-ELIZABETH DOULONG ROBERT FLYNN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sl of Health a item 27 i WILLIAM L. ATWELL / HUSBAND 109 RIVERVIEW ROAD, STEVENSVILLE, MD 21666 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1: Department of I Important: If is any injury or o cemetery, crematory or other place)
CHESAPEAKE CREMATION
CENTER 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/14/2011 STEVENSVILLE, MD 21. Sign the of uneral Service Licenses 22. Name and Address of Facil FELLOWS, HELFENBEIN & NEWNAM FUNERAL 106 SHAMROCK ROAD, CHESTER, MD 21619 HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause o Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE ses f yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ō Day Pregnant at time of death Month Year ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes 2 No Yes 2 funeral director, 25. Was case referred to medic Be 26. Place of Death (Check only one) P Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 🗌 No Investigation Could not be the Accident within 24 hours after deat To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check Certifying Nurse Practifioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated dene siciar

Registrar

State

VAUSALE G

DEC

ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

GOODMANDO

1 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Physician/ ALDRIDGE MARK ALLEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western Maryland Reg. Med Ctr. Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Min (Month, Day, Year) **Director** 235-25-6832 44 April 25,1967 Cumberland, MI Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 X No Mineral Keyser 10e. Street and Number 10f. Zip Code ō 10g Citizen of What Country? Mill Meadow Mobile ral", or items 23a or Examiner must be r Funeral USA 4½ Limestone Road Home Court 26726 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin þ 1 ☐ Never Married 2 🔀 Married Yes Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. Completed | 3 Divorced 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Construction Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lois Eileen Morris Clyde Richard Aldridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26726 P.O. Box 1014 Keyser, Wv April M. Aldridge/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 12/24711 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Funeral Home Crematory 21. Signature or ral Service Lic 22. Name and Address of Facility Smith Funeral Home 26726 Keyser, WV 85 S. Main Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Due (or as a consequence of): Medical **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pulmonary embolism 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an mentral obesity autopsy performed? Yes 2 X No certificate has 1 🗆 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours fer deth. To the Funeral Director After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated MD 12/21/11 D725 14

Registrar

DHMH 17 Rev 06-2011

Willowbrook Rd, Cumberland, MD, 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Liu

5 2012

31. Date filed (Month, Day,

12200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Charles Blaine Alt, Jr. Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Western MD Regional Medical Ctr. Cumberland Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Months 220-16-5387 Director 1 M 2 🗆 F 85 Aug. 20.1926 Antioch, WV Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director or 28a-f sl 1 🗌 Yes 2 💢 No Mineral Keyser 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral Rt. 6, Box 6416 26726 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces' Black, White, etc. Completed by 1 Never Married 2 X Married Y Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: 3 Widowed 4 Divorced Year or Dates. White ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 (GED) College (1-4 or 5+) Electrician/Foreman and Mental Hygier Tire Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental H item 27 is marked of other traumatic eve မ Charles B. Alt, Sr. Etta Shreve 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline F. Alt/ Wife Box 6416 Keyser, WV item 2 other 6, 26726 Date 28 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec. 28 cemetery, crematory or other place) Potomac Keyser, WV Memorial Gardens 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph\_sician/ moumonis disease or condition Medical resulting in death) Examiner Obstruction Pulmonay Desease Charmie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Yes 2 No Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Director: After this certificate has autopsy death? 1 ☐ Yes 2 ☐ No Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA funeral ( 27. Manner of Death .28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending iniury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 12.22.2011 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Willowbanok Ceembertand MIAL

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42445 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Month EARL **EDWARD** ALMOND JR. Medical DEC 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death 10382 CHARLES STREET PLATA CHARLES Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Months Days Hours JUNE 18 WASH., DC Yrs .1942 Director 69 213-40-7766 Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD CHARLES LA PLATA 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 10382 CHARLES STREET 20646 U. S. A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ò Yes 2x No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 BARBER BARBER SHOP is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fil trment of Health and Mental rtant: If item 27 is marked of jury or other traumatic ew and Mental 2 EARL EDWARD ALMOND SR. MILDRED ELIZABETH MONAHAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY ALMOND/WIFE 10382 CHARLES STREET LA PLATA, MD 20646 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot DECEMBER 1 Durial 2 Dremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) METRO . CREMATORY 29,2011 ALEXANDRIA, VA 22. Name and Address of Facility 21. Signatule of Funeral Service Licens RAYMOND FUNL. SERVICE, P.A. the M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or a a conse mence of) **Examiner** Sequentially list conditions, if any, reading to in resolute cause. Enter Underlying Examine Dille to (or be a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Munknown pluods been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page 2 this certificate 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital: \_\_2 💢 No ျှ 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 within 2

To the F only one) 29b. Signature and titl 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 30. Name and address CY . Date filed (Month, Day, 32. Registrar's Signature

Registrar DHMH 17 Rev 7/2009

State

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Ashwell, Ruth M. 290613

			State of Maryland	ack indelible ink. En / Department of Health	•	
			1 - State Registrar	Certificate of Death		g. No. 2011 42448
and the	Physicia Medi	cal	1. Decedent's Name (First, Middle, Last)  RUTH MARIE ASHWELL  48 Facility Name (First Institution give street and number)	I a so s	2. Date of Death  Month  Decembe	
4	Examir	ier	4a. Escility Name (if not institution, give street and number)  CIVISTA MEDICAL CENTO	ER LAPLAT		4c. County of Death CHARLES
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last be a second of Decedent 7. Age (In yrs. last be a second	oirthday) If Under 1 Year If Und Months Days Hours Yrs.	der 24 Hrs. 8. Date of Birth (Month, Day, Y 1 - 1 6 - 1 9	Birthplace (State or Foreign
	ryland I-f shov ied at	Director		wn or Location  LA PLATA		10d. Inside City Limits 1X Yes 2 □ No
	the Ma or 28a oe notif		10e. Street and Number	10f. Zip Code	10	Ig. Citizen of What Country?
	ms 23s	Funeral	1 MAGNOLIA DRIVE	20646		J.S.A.
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Section 1	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1  Yes  No Specif	can, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify HITE
21215-0036	i 72 hou an "nati Medica	Completed	(Specify only highest grade completed)	6a, Decedent's Usual Occupation (Give kind of work done during mo life, DO NOT use retired)	nost of working	6b. Kind of Business/Industry
1212	d withir lygiene ther than nt, the	Be Co	Elementary/Secondary (0-12) College (1-4 or 5+)	HOMEMAKER		OWN HOME
land	be file fental H rked ol tic ever	To B	17. Father's Name (First, Middle, Last)  JAMES F. CHURCH		other's Name (First, Middle, Ma AMANDA HARMO	,
Baltimore, Maryland	id 2 should salth and M n 27 is ma er trauma			9b. Mailing Address (Street and Num B745 VALLEY DR		
more	Page 1 ar			of Disposition (Name of tery, crematory or other place) RLES MEM.GARDE	!	Oc. Location - City or Town, State  LEONARDTOWN, MD.
Balti	permit. P Departm Importa any inju once.		21. Signature of Funeral Service License M00479	Name and Address of Fac	cility NERAL SERVIO	CE.P.A.
	Physician Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a.  Due to (o as a consequence)	espiratory 1	ARYLAND 2064 as cardiac or respiratory arrest	Approximate Interval Between Onset and Death
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	മറ്റ	þ	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Par	art I. 23e. Did tobac	cco use contribute to the cause of death?
ŏ.	law las	Completed	Attal Fibrillation AN	entia dis	24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
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Division of Vital	를 들는 글	icate; To	1 M Inpatient 2 ER/C	Outpatient 3 DOA 28c. Injury at work?  M 1 Yes 2	Nursing Home 5 Residence 28d. Describe how	
JIVISIO	al or Atte s after des Il Directol ed in by th	Certificate	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	ne Hospittiin 24 hours he Funera	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check 2 Medical Examiner: On the basis of examination and only one) 3 Certifying Nurse Practitioner: To the best of my knowledge	or investigation, in my opinion, death	occurred at the time, date and p	place, and due to the cause(s) and manner stated.
	No. With		29b. Signature and title of dertifier	29c. License number	114	1. Date signed (Wonth, Day Year)
	7)		30 Name and address of cerson who completed cause of death (Item 23a)	(Type, Print)	2000 11212	of mo 201002
	Stat Registra	e r	31. Date filed (Month, Day, Year) 2 32. Registrar's signature	West Carrie	Lugar, Wall	2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 1:45 p.m. Allen December Wilfred Berry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 23989 Mill Cove Road Mary's California Birthplace (State or Foreign Country) Social Security Numbe Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** 1 🛣 M 2 🗆 F Days Hours 08/24/191 **Director** 214-03-8032 96 New York Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🂢 No Maryland | St. Mary's California 10e. Street and Number 10f. Zip Code 9 10g, Citizen of What Country? an "natural", or items 23a or Medical Examiner must be Funeral 20619 23989 Mill Cove Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: Completed 3 XWidowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) th and Mental Hygiene.

27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) filed within tal Hygiene. 12 Plumber U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edwin Barton Berry Edith Alma Weeks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Kenneth Berry/Son 23989 Mill Cove Road, California, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) X Burial 2 ☐ Cremation 3 ☐ Removal from State Charles Memorial Cem 12/21/2011 4 Donation 5 Other (Specify) Leonardtown, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Kathleen Santivasci M00872 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cell Physician/ come disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? fo Month Day Year Pregnant at time of death Yes 2 No 9 Unknown detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an certificate has autopsy performed<sup>a</sup> death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending injury 1 Yes 2 No Investigation 24 hours after death Funeral Director: A Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 🗮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 12/19/2011 D2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20659 28227 Three Notch Road, Mechanicsville, MD

State Registrar  $M \rightarrow D$ 

Krishna P. Jayaraman,

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2011

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Charles	I

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	141	1- For State Certificate of Death Reg. No.
Phys		
lical Exa	lmine	Charles Frederick Burroughs December 16, 2011
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Potomac River  Indian Head  Charles
F.,,,,,,,	- 100	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funer Direct	3	Months Days Hours Min.
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any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit
<b>E</b>	يا ايو	1 Yes 2 N
urylan		MD Charles Charlotte Hall  10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
he Ma	Director	13275 Ryceville Road 20622 USA
sath with the Maryland items 23a or 28a-f show	2 2	
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within iene.	he Medical Examine Completed by	12 Sheet Metal Worker Sheet Metal  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
215-0036 be filed within 7 ntal Hygiene. rked other than	4 0	
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho	o Be	
MD 2 d 2 shou lth and N	T   g	Edward Stanley Burroughs, Jr/Dad 13275 Ryceville Road Charlotte Hall, MD 20622
a di di	T I	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
Baltimore, permit. Pages I a Department of He Important: If ite		1 K Burial 2 Cremation 3 Removal from State crematory or other place)
ti Pa	9	4 Donation 5 Other Specify: All Faith Episcopal 12/21/2011 Charlotte Hall, MD  21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2
Baltimo permit. Page Department o Important:	in in	M00817  M00817  Brinsfield-Echols Funeral Home 30195 Three Notch Road Charlotte Hall, MD 20622
Physicia		23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interva
∖/Medic		failure. List only one cause on each line.  Between Onset and Death
Examin	er	Immediate Cause (Final disease or condition resulting in death)  a. Drowning Complicated by hypothermia  a. Drowning Complicated by hypothermia  Due to (or as a consequence of):
		Sequentially list conditions, b
		if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause
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Box 68760, e death certificate be the attending physic	ched for use as the buri	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
68 Sertifi	se as	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year  4 Pregnant at time of death 5 Other (Specify)
Sox leath e atter	for u	1 Yes 2 No 9 Unknown 9 Unknown
P.O. Box 68760, that the death certificate be ex ned by the attending physician	P ached	
P.O. es that th	be det	1 Yes 2 No 3 Probably 4 Unknown
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F. Th	g 8	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be him 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physici	director, page	examiner? Hospital: 4 Inspired: 2 EB/Outcation: 2 DOA Other, Nursing Home 5 Pasidance 6 Other: Scene
g Phy	funeral on: To	27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred
endin ath.		1 ☐ Natural 5 ☐ Pending Dec 15, 2011 1818 hrs 1 ☐ Yes 2 ✔ No Subject drowned
Division tal or Attendir rs after death.	i by	2 V Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Cit or Town, State)
E ag	Certification:	Suicide Suicid
Hosp 24 ho Fune		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	completely Medical	(check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
FSF	°   W	
•		O.C.M.E. December 17, 2011
004	AF.	30. Name and address of person with completed cause of death (Item 23a)
nue Och	***	Mary G. Riople MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
		31. Date filed (Month, Day, Year) 32. Begistrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month 12 28 2011 11:58 A M Joseph Kingston Beale, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Lexington Park 21546 Forest Park Road If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 🗓 M 2 🗆 F Hours 7 / 25 / 1947 Country) Director 219-46-3484 64 MD Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No St. Mary's Lexington Park MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21546 Forest Park Road 20653 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, þ 1 Never Married 2 Married X Yes Yes, Give within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", Specify: 3 Widowed 4 X Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry Je filed with... \*\*al Hygiene. \*\*ar than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Computer Science 2 should be filed with h and Mental Hygien 7 is marked other ti Engineer Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Pau1 Lucille Kates Beale Lattimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Friend 48011 Mary Lynn Drive Lexington Park, MD Virginia I. Salisbury / Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols 12/29/2011 Charlotte Hall, MD 21. Signature of Funeral Service Licensee M00817 22. Name and Address of Facility Brinsfield-Echols Funeral Home P.A. 30195 Three Notch Road Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ nsilla disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sician and burial-trans resulting in death) Last Due to (or as a consequence of) physician Physician/Medical that the death certificate be Box 68760 the nding pluse as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Dav Year Other (specify) Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Jas 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{\text{\text{Nursing Home}}}\) Nursing Home 5 \(\text{\text{Residence}}\) Residence 6 \(\text{\text{\text{Other}}}\) Other (Specify) 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Hospital or Attending iniury 5 Pending 1 Yes 2 No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident Investigation 6 Could not be Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ only one) 29b. Signature and titl 29d. Date signed (Month. Day. Year) 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) Schmidt, D.O. 40900 Merchants Lane, Leonardtown, MD 20650 Jen\_ifer 31. Date filed (Month, Day, Year)

State

Registrar

**DEC 29** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month / 12/17/2011 Physician/ Mary Agnes Brenner 5:55 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hartley Hall Nursing Home And Rehab Pocomoke City Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 220-32-4449 11<sup>M</sup>29 PY934 77 MD **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Pocomoke City 1

Yes 2 □ No Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 704 Walnut St. 21851 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married Completed by 1 ☐ Yes If Yes, Give 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 🗆 Widowed 4 🗆 Divorced Specify: White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Garland Winters Mary Teresa Meagher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health airtem 27 i 704 Walnut St., Pocomoke City, MD, 21851 Page 1 and 2 Nelson E. Brenner/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o of 1 X Burial 2 Cremation 3 Removal from State 12/20/2011 4 ☐ Donation 5 ☐ Other (Specify) First Bapt.Ch.Cem. Pocomoke City MD 21. Signature of Fun A Service Licensee 22. Name and Address of Facility Holloway Funeral Home P.A. 107 Vine St., Pocomoke City, MD, 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. estovasa disease or condition 包火 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 No certificate 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 KNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this in by the funeral dir 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No 1 Natural 5 Pending injury ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) hin 24 hours af the Funeral Di Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed (Month, Day, Year) 12-15-201 1550422 BARAL, MI SARAD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1604-31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 2011 State
Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03101 2011 Medical 4a. Facility Name (if not institution, give street and number) or Location of Death
Annapolis 4c. County of Death Arundel Examiner Ginger Cove Health Center 8. Date of Birth
(Month, Day, Yes . Social Security Number 255–26–3624 If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F 86 Months Director Georgia Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 28a-f 1 Yes 2 XXVo 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country?  $U_{\bullet}S_{\bullet}A_{\bullet}$ Funeral 3307 River Crescent Drive 21401 23a items ; 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Fo Black, White, etc ō þ 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give 1945-75 Year or Dates. Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify. "natural", Completed 3€XWidowed 4 ☐ Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Mediconce. (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Captain U.S. Navy Be 17. Eather's Name (First, Middle, Last)
Alva M. Bowen, Sr. 18. Mother's Name (First, Middle, Maiden Surname)
Julia Culpepper ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Bowen/son 1131 Elden St. Herndon, Virginia 20170 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Kremation 3 Removal from State Baltimore Crematory 12/16/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sig Fun al Service License 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) 146 my sarcome Medical Due to (or as a consequence ou Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of limiting y that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burialby Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Day Pregnant at time of death 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed 2 No 3 Probably 4 ☐ Unknown this certificate has been si al director, page 2 should I 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ျှ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending thin 24 hours after death.

the Funeral Director: Alempleted filled in by the fu 1 Yes Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the h within 2. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Marian Parrott, MD tense 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** December 14 2011 Philip Miller Baer Jr. /Medical 4c. County of Death

Somerse + Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Aurora Senior Living of Manokin Princess Anne 8. Date of Birth (Month, Day, Year) 07/02/1929 Birthplace (State or Foreign Country)
\_\_\_\_\_\_ 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**X** M 2□ F Months Hours 82 Maryland Director 213-28-9632 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show with it item 27 is trained other than "natural", or items 23a or 28a-f show ant; If item 27 is marked other than and the other trained as a second of the property of 1 □Yes 2 X No Directo Maryland Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21804 617 Sherwood Circle Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11, Marital Status Armed Forces?
1 XYes 2 ☐ No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: Army 1 ☐ Yes 2 XNo White Specify. Be Completed by Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Store Manager Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irma Elizabeth Seipell Philip Miller Baer Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 617 Sherwood Circle, Salisbury, MD 21804 Blanche H. Baer/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place Wicomico Memorial Park 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/21/2011 Salisbury, MD □ Donation 5 □ Other (Specify) 21 Signature of Funda Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Monpson Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Demertra disease or condition resulting in death) 54 wan /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and s the burial-trans Due to (or as a consequence of): Physician/Medical been signed by the attending proposed should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal deal 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) I Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ≥ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has I autopsy performed? spital or Attending Physician; The ours after death, seral Director; After this certificate I filled in by the funeral director, page 1 ☐Yes 2 ☐ No 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide e Hospital of 24 hours at Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. To the I within 2

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

State Registrar

31. Date filed (Mon

29b. Signature and title of certifier

July NEWON

DR. USHA

NATESAN 1415 Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S.DIVISION

29c. License number

1051359

29d. Date signed (Month, Day, Year)

ST. SALISBURY MD 21804.

December 15/5 2011

42453

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ШO	Page 1 nent of int: If i		1 ☐ Burial 2 4 ☐ Donation			al from State	CE	emetery, c <del>r</del> en	natory or other place te Crem.			/2011			•		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner.		21. Signature of Fu							ddress of Facility The Burbage Fune liam St. Berlin, MD 21811							
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68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent	pregnant	23c. If <u>ye</u>	es, outcome	of <u>pr</u> egnar							23d. Date	of delive	W//	
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P.O.	at the d by th		g ☐ Unknown Part II. Other signif	icant condition			ut not resu	nderlying cause giv	ven in Part I.		23e Did to	d tobacco use contribute to the cause of death?					
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lon	eath. or: Aft	ficat	1 Accident 2 Accident 3 Suicide	5 ☐ Pendin Investig 6 ☐ Could	ation	(Month, Day	; rear)	injury	M 1 □	? Yes 2□N	10						
Division of Vital	or Att after d Direct in by	Certificate:	4 Homicide	determ		Place of Injubuilding, etc			et, factory, office	28f.	itreet ar n, State	et and Number or Rural Route Number, State)					
	ospital hours ineral d filled	Medical	29a. Certifier	Certifying	Physician: To	the best of	my knowle	edge, death o	ccured at the time,	, date and pla	ace, and du	ue to the cau	use(s) a	nd manner	as state	d.	
	the He hin 24 the Ft the Ft	Mec	only one) 3	Certifying					eath occurred at the	e time, date a		nd due to the	e cause(	(s) and mann	ner as sta		
	<b>८</b> № ८ छ		29b. Signature and	title of certifier	llain				29c. License				29d. Da	ate signed (i	Month, [	Day, Year)	
			30. Name and add	ss of person	vho complete	d cause of de	eath (Item	23a) (Type, P	D006	0107				1-1	17]1	1	
	ET	15	Angela G	ibbs MI	10445			-		, Berl	in, N	1D 218	11				
	Stat Registra		31. Date filed (Mont	DEC 1	6 2011	32. Røgistra	r's Signatu		arked								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible link Finsure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 John S. Britten December 5:49 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 2716 Jennings Chapel Road Woodbine Howard Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Min (Month, Day, Year) 577-46-5774 Director 1 □**X**M 2 □ F 78 Feb.22, 1933 NY Usual Residence of Decedent 28a-f show 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2X No Howard Maryland Woodbine 6 10e. Street and Number 10g. Citizen of What Country? must be 23a Funeral 2716 Jennings Chapel Road 21797 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 No Yes, Give 9 by 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. White "natural", Specify: 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) the Physician Medical other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ဂ္ Sidney Adams Britten Isabella Shoudy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Health 2716 Jennings Chapel Rd., Woodbine, MD 21797 Alice Marianne LaFever/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 A Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/10/2011 | Frederick, MD Stauffer Crematory . Signature of Funeral Service L 22. Name and Address of Facility Stauffer Funeral Homes, P. A. 1621 Opossumtown Pike, Frederick, MD pater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): ohysician and the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be ast IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month jo Year Month Day Pregnant at time of death 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law has perform 2 🗆 No Yes 2 1 Ves To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident Pending 1 Yes 2 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signati 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print) Sandy Kotiah

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

1

Box 68760

P.O.

Records,

of Vital

Division

32. Pigistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HRIAN KEAUC Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death Medico Wasting by Agerstown . Age (In vrs. last birthday **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🛛 F Months 88 Director 239-30-4048 03/17/1923 North Carolina 28a-f show 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits **Funeral Director** MDWashington Hagerstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20014 Rosebank Way Apt. 307 21742 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) other Beautician Hair & Beauty Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ည Charles T. Plybon Donna Burwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health attem 27 <u>Helen B. Dickinson / Daughter</u> 197 Fairfield Drive, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State ± 6 pertrit. Page Det artment o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 12/22/2011 Smithsburg, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Hymxic disease or condition resulting in death) Medical Due to (or as a consequent of) Examiner PNEUMONIA Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): e attending physician .... ما ثمار se as the burial-traneit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2  $\square$  No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy Hospital or Attending Physician: The Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes s after death Investigation Could not be 2 🗌 No Accident Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours after To the Funeral Dir Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 🗌 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Merites Medical State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month December Kenneth Lee Bowman 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Boonsboro Fahrney-Keedy Home and Village 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) 1 X M 2 □ F Hours May 26, 1936 214-34-0182 75 Maryland **Director** Usual Residence of Decedent 28a-f shov with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 216 Montclair Ct. 21740 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 761 - Yes, Give 1965 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 5 Department of Health and Mental Hygiene. Important: If item 27 is marked other thar any injury or other traumatic event, the M College (1-4 or 5+) Elementary/Seconday (0-12) Self Employed Mechanical Designer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Daugherty Samuel Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 216 Montclair Ct. Hagerstown, MD 21740 Mary E. Bowman-wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 12-22-2011 Rose Hill Cemetery Hagerstown, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home natur of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicien/ PARKINSO-VIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a d be detached for Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PULMOWARY OBSTRUCTIVE DUSENS. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ARTERY DISKASE NYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy MERIS DISBASE ALZERI performed? certificate Be ( 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation 24 hours after deat Funeral Director: 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho
To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DD018019 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST HAGERSTOWN MD 21740 340 m.11 VASAN MD

DHMH 17 Rev 7/2009

Registrar

Lenet

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 16, Leon Bly 2011 8:40 p December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Ritchey Hospice Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Year) 1949 Maryland 219-54-6693 Director Jan. 62 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location Director Baltimore 1 Yes 2 No Maryland 10e, Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be n Funeral 828 North Eutaw St. 21201 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Was Deceuein 2. Armed Forces? 1 Yes 2 No the Medical Examiner Black White etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 - Widowed 4 - Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Musician and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Margaret Grey Leo M. Bly injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11615 Jovita Jesse Place, Nanjemoy, Md. 20662 Joseph Patrick Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec . 19 Pat 2011 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Alexandria, Virginia Metropolitan Funeral Service 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
Williams Funeral Home, P.A. M00668 20640 4270 Hawthorne Rd., Indian Head, pase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. 23a. Part 1. Enter the dis shock, or heart fail Immediate Cause (Final Approximate Interval Between Onset and Death Phylician/ Cancer with disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due t (or as a consequence of): Exami Due to (or as a consequence of): resulting in death) Last attending physician at for use as the burial-Physician/Medical 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown P.O. rate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ hypertension 1 Yes Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed and drug abuse 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 2 🗌 No 1 Yes 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir ō 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work 1 Yes 2 No 2 Accider
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

Jaseph

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Meni

Day, Year) 21 2011

11-09559 John Paul Braith	wai	Please Type or Pr	int in Black Ind laryland / Depar						gible.	001	1 1015
		1- For State Registrar			f Death				Reg. No.	201	1 4245
Physicia Medical Exami	in/	1. Decedent's Name (First, Middle,Last)  John Paul Braith			Al- O'L Tou		continue of Dooth	2. Date of De Month Decembe	Day er 20, 20	Year 111 County of Deat	3. Time of Death 1352 hrs
		4a. Facility Name (if not institution, give stree Western Maryland Regional Me			Cumber		ocation of Death	1		egany	n
Funeral		Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	if Under 1	Year	If Under 24Hrs	s. 8. Date of B	irth(MM/DE		rthplace (State or
Director		219-54-1949 1X M 2	2□F 56	Yr		Days	Hours Mir	Dec.4	, 195	5 Forei	ountry) Keyser,
and show any nce	ō	10a. State 10b. County  MD Allegany		own or Loca							10d. Inside City Limits 1 X Yes 2 No
Maryl r 28a-i	rect	10e. Street and Number	-		10f. Zip Co	de			10g. Citize	n of What Cou	untry?
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er death wi	Funera		Vas Decedent Ever in U.S.  Immed Forces?  Yes 2 No Give Year	lf `		uban, I	anic Origin? (S Mexican, Puerto			White, etc.	
urs afte		15. Decedent's Education (Specify only high	es:	i6a. Deceoe	nt's Usual Oc	upatio	rı (Givə kind of			d of Businass	White
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23n or 23n-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Completed		Dilege (1-4 or 5+)		nost of workin aborer		OO NOT use ret	ired)		onument nufactu	
5-0( led wi Hygier other	ပိ	17. Father's Name (First, Middle, Last)	12		aborer		.Mother's Name	e (First, Middle	Maiden Su	ırname)	
MD 21215-0036 of 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medical	To Be	Arthur Theodore Bra 19a. Informant's Name/Relationship (Type, Pr	ithwaite	19b. Mailir	ng Address (	Street e	Alma L. end Number or	Smith Rural Route Nu	ımber, City	or Town, State	e, Zip Code)
MC 2 sladth arms 7 mm 27		Carolyn S. Braithwa			12 Sto		Run Ro	ad Wes	tern	cation - City o	1D 21562
Ore, es la of He urite		1 Burial 2 X Cremation 3 Re	moval from State cre	ematory or o	ther place)		Dec	. 28		·	
Baltimore, cernit. Pages I a Department of He Important: If ite injury or other training or other trai		4 Donation 5 Other Specify:	Smit	th Fun	eral H	ome	Cremat				WV
Bal Bal Permit Depar Impor		21. Signature of Funeral Service Licensee	116		Name and Ad		SIII	ith Fur			0.6
Physician	$\dashv$	23a. Part I. Enter the disease, or complication		o not enter	the mode of d	ing, su	Street uch as cardiac o	or respiratory a	rest, shock	c, or heart	Approximate Interva
/Medical Examiner			hyxia (or as a consequence of):							<del>.</del>	Between Onset and Death
	iner	cause. Enter Underlying Cause	(or as a consequence of):								
cuted and transit	al Examiner	events resulting in death) Last Due to	(or as a consequence of):								
oe exe		X UNPENDED AME	<sub>NDED</sub> 23a,27,28	Ba−f,p	er me,	392	3 1-9-1	2 sm			
68760 ertificate b ding physi	Physician/Medic	12h 14/as desertant assessed in the	If yes, outcome of pregna Live birth Pregnant at time of deat	2 F	etal death	3	Ectopic pregna	ancy		Date of deliver onth	Day Year
Sox death of e atten for us	ysic	1 Yes 2 No 9 Unknown 9	Unknown	n 5 0	ther (Specify,	_					
P.O. E es that the igned by the detached	<u>a</u>	Part II. Other significant conditions contril	buting to death but not res	ulting in the	underlying ca	ıse giv	en in Part I.				the cause of death?
Division of Vital Records, P.O. Box 68760, To the Broppial or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial —transi	Completed								opsy orm <u>ed</u> ?	prior to death?	utopsy findings available completion of cause of
E Re	ပ္ပို	25. Was case referred to medical			26.1	lace o	f Death (Check		2 No	1 🗸 Y	es 2 No
Vita ysicia his cer direct	Be	examiner?  1  Yes 2 No	1 Inpatient 2 🗹 E	R/Outpatien					Residenc	e 6 Othe	er:
on of cading Ph ath. rr. After the funeral	tion: To	27. Manner of Death  1 Natural 5 Pending	(Month, Day,Year)	28b. Time of			at Work? s 2 X No	28d. Describe hangin activi	g dur	occurred Acting au	ccidental toerotic
Divisitital or Att	Certification:	3 Suicide 6 Could not be	Be. Place of Injury - At hom Specify) Residen	ne, farm, stre		ice bui	lding, etc.	28f. Location or Town, Wester	(Street and State) 24 nport	Number of R 112 St ,Md.	ural Route Number, City Oney Run Ro
o the Hosp ithin 24 hot o the Funer ampletely fil	Medical C	29a. Certifier 1 Certifying Physician: To (Check only one)						d due to the car	use(s) and	manner as sta	ited.
F . F E S	₩.	29b. Signature and title of certifier	enno stateu.		29c. Li	cense	number		29d. Da	ite signed (Mo	onth, Day, Year)
		Please of person who comple	M) ted cause of death (Item 2	3a)	C	.C.M	.E.		Dece	mber 21, 2	2011
7			stant Medical Exam		0 W. Baltir	nore	Street, Balt	imore, MD :	21223		
St	ate	31. Date filed (Monter Day) (Very)	32. Registra s Signature	west.					-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not Institution, give street and number) Examiner 4c. County of Death . Age (In yrs. If Under 24 Hrs Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Days Hours TOINICA Months Director Usual Residence of Decedent 10a. State 10b, County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location by Funeral Director 10d. Inside City Limits be notified 28a-1 1 Yes 2 No Ollo NKC ō 10e. Street and Number 10g. Citizen of What Country? 23a must Irinidad + TAbago Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or i 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a St College 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ö ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 30/2011 4 Donation 5 Other (Specify) Funeral Ser 1425 Signatur 22. Name and Address J Facility ten DC 20002 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Betweer Onset and Ceat shock, or heart failure. List only one cause on line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to lo Examiner Sea continue list o en litte in Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Live Birth 2
Pregnant of 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 1 Yes 2 L 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗓 3, Probably 4 Unknown 1 Yes Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 25. Was case referred to p examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Mann f Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) injury 5 Pending 1 Tes 2 No Accident Investigation M 6 Could not be determined Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

2255 To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760 Dall P.0. Division of Vital Records, within 24 hours after death.

To the Funeral Director; After this certificate | the Hospital or Attending Physician: Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert bay, Year) State Registrar DHMH 17 Rev 7/2009 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month December Physician/ ARIZA CENIZA 7:25 AM FANIA 20 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 SKF Days Hours Min. (Month, Day, Y Philippines 220-43-5394 1938 Director Tan. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Fallston Harford Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21047 2902 Sedgefield Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No þ 1 Never Married 2 Married 1 Yes 2 No Specify: DCD (3/3C) | TOD ( Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Completed 3 Widowed 4 □ Divorced Filipino Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Pharmacy Pharmacist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Facunda (nmn) Plaza Juan (nmn) Ariza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other tra-813 Sidehill Drive, Bel Air, Maryland 21015 Amelia C. Hentschel/Daughter 20c. Location - City or Town, State Mandaue City, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1-4-2012 Burial 2 Cremation 3X Remov from Sta nation 5 🗆 Other Angelicum Garden of Angels 4 🖂 (Specify) Philippines 22. Name and Address of Facility of Funeral Se 21. Sign McComas Funeral Home, P.A. Þ 317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pancreatic Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Jeniza, Epitania cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe n800457943 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 🗆 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) December 20, 2011 00063653 08 Upper Chesapeake Drive Bel Air, Moraland 21014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 strar's Signature State

Registrar

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30. Name and address of person who completed cause of death (Item 23a)			()(	kuler	M	()					O.C.	M.E.			Dec	ember 21, 2	011	
(A) (A)			30. Name and addre	ess of person v	vho co	mpleted caus	e of dea	th (Item 2	(3a)									
Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223					sista					. Baltimo	re Stree	et, Baltim	nore, ME	21223				
State 31. Date filed (Month, Day, Year)  Registrar  DEC 2 2 2011  32. Registrar's Signature		_	31. Date filed (Mont	FC 9.9	201		_	Signature		back	1							

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ORIGINAL

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12/772011 Physician/ 346pm M Lucille Hale Charles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PG New Carrollton 8304 Nicholson Street If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 577-10-1798 1 □ M 💥 😿 F Director 97 3/23/1914 VA Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 1 Yes XX No PG New Carrollton MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number must be n Funeral 20784 USA 8304 Nicholson Street er than "natural", or items the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XXVo þ Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 ₩Widowed 4 □ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 }
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event". Elementary/Secondary (0-12) College (1-4 or 5+) Officer 0 Dept of Navy Procurement Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ <u> William Sydney Hale</u> Lula Baird 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kathy Hillegas **Grandchild** Frost Valley Lane Gambrills, MD 21054 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition NX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hill Cemetery Suitland, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Dicensee 0. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ End disease or condition Medical resulting in death) Examiner yesrs Sequentially list conditions, cause. Enter Underlying Examin Cause (Disease or injury that initiated events resulting in death) Last use as the burial-transi Due to (or as a consequence of): attending physician Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No • Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate I filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify, 1 Yes 2 WNo 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geam occurred at the time, vale and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2. only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0040519 12-9-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1667 Crofton Centre Ste.l Crofton, MD 21114 MD Mirza Nusairee, Registrar's Signatur State 1 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 27,27,28a-f per me g924 2-2-12 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 December 1353 Рм Gladys C. Courter Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Union Hospital Ceci1 E1kton Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Days Hours Min AUG 14. 1909 102 Towa Director Yrs 483-24-4706 Usual Residence of Decedent show or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Ceci1 Earleville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 44 Pocahontas Drive 21919 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black. White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates Specify: White 1 ☐ Yes 2 👿 No Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker In Her Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Telschow Augusta Albrecht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlo T. Courter/Son 44 Pocahontas Drive, Earleville, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🎇 Burial 2 □ Cremation 3 □ Removal from State December 4 Donation 5 Other (Specify) Hockessin Friends 27, Hockessin, DE 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Myocardia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PILLE Sequentially list conditions. THON APPROVED BY MEDICAL EXAMINER Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Day Year 5 Other (specify) 1 Yes 2 9 Unknown 9 I Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an the Hospital or Attending Physician: The law After this certificate has autopsy Yes 2€ 25. Was case referred to medical examiner?

1 X Yes 2 No **Division of Vital** Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 잍 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 🔀 No 5 Pending X Accident 12-17-2011 subject fell after death Investigation unknown<sup>M</sup> Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1881 Telegraph Rd. Homicide determined Rising Sun. within 24 hours a To the Funeral D Nursing Home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 29b. Signature and tife of certifier 29d. Date signed (Month, Day, Year) December 20, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 21921 106 Bowst 056 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Physician  Medical Examiner  1. December 10, 2011  Reggie Eugene Crawford  2. Deate of Death  Reggie Eugene Crawford  4a. Facility Many (Froit installation, give street and number)  Prince Georges Hospital  Fundant  Director  1. Social Security Number  1. Social Social Security Number  1. Social	pe or Print In Black Indelible Ink. Ensure All Copies Are Legible.	
Physician/ Medical Examiner  1. Discedents Name (First, Middle, Last)  Reggie Bugene Crawford  1. Discedents Name (First, Middle, Last)  Reggie Bugene Crawford  1. Discedents Name (First, Middle, Last)  Reggie Bugene Crawford  1. Discedents Name (First, Middle, Last)  Reggie Bugene Crawford  1. Discedents Name (First, Middle, Last)  1. Discedents Name (First, Middle, Last)  1. Discedents Name (First, Middle, Last)  1. Social	7/11/1	1246
Reggie Eugene Crawford  4e. County of Death Prince Georges Hospital  Fundari  Director  5. Social Security Number of the County Prince Georges Hospital  5. Social Security Number of the County Prince Georges Hospital  5. Social Security Number of the County Prince Georges Hospital  6. Social Security Number of the County Prince Georges Hospital  6. Social Security Number of the County Prince Georges Hospital  7. Age (fr yrs. least birtholay) Prince Georges Hospital  8. Social Security Number of the County Prince Georges Hospital  8. Social Security Number of the County Prince Georges Hospital  9. Social Security Number of the County Prince Georges Hospital  9. Social Security Number of the County Prince Georges Hospital  9. Social Security Number of the County Prince Georges Hospital  9. Social Security Number of the County Prince Georges Hospital  9. Social Security Number of the County Prince Georges Hospital  9. Social Security Number of the Security Prince Georges Hospital  9. Social Security Number of the Security Prince Georges Hospital  9. Social Security Number of the Security Prince Georges	Certificate of Death Reg. No.	,
4a. Facility Name (if not institution, give street and number)  Finner Georges Hospital  Finner Georges Hospital  5. Social Security Number  6. Sex   7. Age (in yrs. last birtholay)   Under I Year   if Under 24 ths.   Social Security Number   Soc	Month Day Year Land	
Second Security Number   Sec		
State   10b County   10c State   10b County   10c State   10b County   10c State   10b County   10c State   10b County   10c State   10b County   10c State   10b County   10c State   10b County   10c State   10b County   10c State   10b County   10c State   10b County   10c State   10b County   10c State   10b County   10c State   10b County   10c State   10b County   10c State   10b County   10c State   10b County   10c State   10b County   10c State   10b County   10c State   10c County   10c County   10c State   10c	pital Cheverly Prince George's	
State   Total State   Total	Months Days Hours Min Foreign	ate or
To State   10b. County   10c. City, Town or Location   10c. City,	1XM 2F 31 Yrs. Moltals Beys 11688 11/23/1980 Country) 1	DC
Md. Prince Georges Temple Hills  10e. Street and Number 312 2 8th Parkway  10f. Zpp Code 20748  10g. Clitzen of What Country? USA 2074 8  11 Marital Status 11 Marital Status 11 Marital Status 11 Marital Status 11 Marital Status 11 Marital Status 11 Marital Status 11 Marital Status 11 Marital Status 11 Marital Status 12 Maried Forces? 11 Marital Status 13 Wes Decedent of Hispanic Origin? (Specify Yes on No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Yes, 2 No. In	y 10c. City. Town or Location 10d. Insic	de City Limits
The part of the	TZ	s 2 No
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The part of the	Parkway 20748 USA	
The part of the		, Black,
Physician Integrical Xaminer  21, Signature of Funeral Service Licensee  22, Name and Address of Facility 2019 MLK Ave., SE, Wash., DC 20020  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  d.  Due to (or as a consequence of):	1 Yes 2 X No	
Physician Integrical Xaminer  21, Signature of Funeral Service Licensee  22, Name and Address of Facility 2019 MLK Ave., SE, Wash., DC 20020  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  d.  Due to (or as a consequence of):  Due to (or as a consequence of):	or Dates:	
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failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  d.		
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- transfer and and and and and and and and and and	Due to (or as a consequence of):	
- transfer and and and and and and and and and and	· · ·	
	d.	
9 ag 23d. Date of delivery	AMENDED	
23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy  Month Day Year	Personant of time of death	Year
The state of the s	Jelenous Julian (Specify)	1
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	The state of the s	
1 _ Yes 2 ✓ No 3 _ Probably 4 _ Unknown	1 Yes 2 V No 3 Probably 4	Unknown
So Diagrams of the part of the	autopsy prior to completion	
24a. Was en autopsy findings ava per outopsy performed?  1 ✓ Yes 2 No 1 ✓ Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N		2 No
23e. Did tobecco use contribute to the cause of death part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.  23e. Did tobecco use contribute to the cause of death part II. Other significant conditions contribute to the cause of death part II. Other significant conditions contribute to the cause of death part II. Other significant conditions contribute to the cause of death part II. Other significant conditions contribute to the cause of death part II. Other significant conditions contribute to the cause of death part II. Other significant conditions contribute to the cause of death part II. In part II. Other significant conditions contribute to the cause of death part II. In	31. 34.	
examiner?    Solid   S		
27. Manner of Death  28a. Date of Injury Dec 10, 2011  1 Natural 5 Pending  28a. Date of Injury Dec 10, 2011  1 Yes 2 V No  28d. Describe how injury occurred Driver auto auto collision	(Month, Day, Year)	
Pending Investigation 2  Accident 3  Suicide 6  Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number or Ru	vestigation 28e Place of Injury. At home form street factory office huilding etc. 28f Location (Street and Number of Pural Poute	Number, City
O serious auto collision  1 Natural 5 Pending Investigation  2 Accident 3 Suicide 6 Could not be determined 5 Specify Major Road / Highway  2 Sec. Initially 2	or Town, State)	
Pending   Pend		
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Date signed (Month, Day, Year)	xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s	)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	ifier 29c. License number 29d. Date signed (Month, Day, Y	(ear)
6 December 12, 2011	O.C.M.E. December 12, 2011	
30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD. Assistant Modical Examples 900 W/ Paltimore Street Paltimore MD 21223		
Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year) 32. Régistrar's Signature	22 Paristrate Signature	
Registrar DFC 21 2011 Server B. Jack	+ 2011   B B B B B B B	

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			- State Registrar			Certifica					Reg. No.	201		42465	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)							<ol><li>Date of De Month</li></ol>	Day		ar	3. Time of Death	
and in the	Medic	al	Anna Virgini 4a. Facility Name (if not institution, give st		t	14. 00	T	Location of	Death	Decemb		County of D		3:00 a <sup>M</sup>	
may de	Examin	er	1109 S. Schumaker	Dr., Apt.		5	Salisk			0. Data of Div	_ [_ [v	co	and (Chata on Familia)		
	Funeral Director			МаГФЕ	(In yrs. last birtho	Months		Hours	Min.	8. Date of Bir (Month, Da	ıy, Year)		Birthplace (State or Foreign Country)  lassachusetts		
	show at	'n	Usual Residence of Decedent  10a. State  10b. County		10c. City, Town o	or Location				_07/00/	1913	/ 1.1		Od. Inside City Limits	
	Maryla 8a-f s tified	Director	Maryland Wicomico		Sa]	lisbury	7							1 🏿 Yes 2 □ No	
	h the		10e. Street and Number			10f. Z	ip Code				10g. Cit	izen of What	Count	ry?	
	ms 2%	Funeral	1109 S. Schumake	r Dr., Ap		12 Mas Door	21804		n2 (Sne	cify Yes or No-		USA	morios	an Indian	
9	er dea or ite miner	by Fi	11. Marital Status  1 Never Married 2 Married	Armed Forces?  1 Yes 2 X 1					Puerto I	cify Yes or No- Rican, etc.)			nce - American Indian, ack, White, etc.		
003	urs aff :ural", al Exa	ted	3 🛣 Widowed 4 □ Divorced	If Yes, Give Year or Dates.		1 L Yes	2 <b>X</b> No	Specify:				Specify:	Wh	ite	
15-(	72 hoi n "nat fedica	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(0	ecedent's Us Give kind of w fe. DO NOT u	ork done d	ition uring most o	of workii	ng	16b. K	ind of Busine	ss/Ind	ustry	
21215-0036	ed within 72 hours after death with the Maryland thygiene. thysiene "natural", or items 23a or 28a-f sho ant, the Medical Examiner must be notified at		Elementary/Secondary (0-12)	College (1-4 or 5-	F)	Adminis	,	or			H∈	alth	Car	e	
73	교수들법	To Be	17. Father's Name (First, Middle, Last) William Henry Har	ris						e (First, Middle, e Limor		Sumame)			
ary	should be file and Mental F is marked o raumatic eve		19a. Informant's Name/Relationship (Type	e, Print)	19b. N	Mailing Addre	ss (Street a	nd Number	or Rura	l Route Numbe	er, City or	Town, State	Zip C	ode)	
	and 2 s Health a tem 27 i		Donna Anderson/Da	ugnter ————				ord Dr		Salisbu					
Baltimore,	ge 1 a nt of H : If ite or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ F	emoval from State	20b. Place of December of Arlingt	Disposition (Nation of Nation)	ame of other place			Date	1	ocation - City			
Itim	tmel tand jury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee		C	meter	7	s of Facility	)3/I	9/2012	Arı	ingto	n,	VA	
Ba	permit Depar Impor any in		D K C			Hollo	owav 1	unera	al H	ome Pro	ofess	sional	AS 180	sociation	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line.											F	Approximate Interval Between	
,I	hysician	81 1	Immediate Cause (Final disease or condition			MSCV	>							Onset and Death	
The state of	Medical Examiner		resulting in death)	Due to (or as a	consequence of)	:									
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of)	:							+		
	executed an and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										1		
		I— I	resulting in death) Last	Due to (or as a	consequence of)										
68760	ath certificate be a attending physicie for use as the bu	edic	d										+		
89	certific nding use at	M/u	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of								23d. Date of	f delive	ery	
Вох	death he atte ed for	Physician/Medica	in the past 12 months?	4 Pregnant at	Fetal death time of death	5 Other		у				Month		Day Year	
P.O.	hat the dea ed by the a detached f		g ☐ Unknown  Part II. Other significant conditions con	tributing to death bu	it not resulting in	the underlyin	g cause giv	en in Part I.		23e. Did	tobacco u	ise contribut	e to th	e cause of death?	
S, F	uires that signed Ild be de	d by								1 🗆	Yes 2	□ No 3 [	Prob	pably 4 🗆 Unknown	
of Vital Records,	w require s been si 2 should l	Completed								24a. Was		24b. Were	autop	osy findings available mpletion of cause of	
Rec	The law ate has page 2	Som								auto perf	ormed?	deat	h?	2 No	
tal	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:				ace of Death	n (Check	only one)					
Ϋ́	Physi this c	<u>۲</u>	1 ☐ Yes 2 ☐ No ☐ ☐ Yes 2 ☐ No ☐ ☐ Yes 2 ☐ No ☐ ☐ Yes 2 ☐ No ☐ ☐ Yes 2 ☐ No ☐ ☐ Yes 2 ☐ No ☐ ☐ Yes 2 ☐ No ☐ Yes 2 ☐ Y	1 Inpatie	nt 2 ER/Outp		DOA Othe	4 ∐ Nur		me 5 Resi 28d. Describe			pecify)	)	
o uc	nding l ath. :: After ie funei	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,			work		- 1	200. Describe	now injui	y occurrou			
Division	I or Attendi after death Director: A d in by the f	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju		n, street, facto	ory, office			28f, Location (			Rural	Route Number,	
قَ	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 24 hours after death size continuate the seen signed by the attending physici To the Euroral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Medical C	29a. Certifier 1 Certifying Physic	cian: To the best of r	ny knowledge, de					nd due to the o	cause(s) a	nd manner a			
	To the Ho within 24 To the Fu completel	Meo	only one) 3 Certifying Nurse			edge, death o	courred at t	ne time, date			the cause	e(s) and mann	ner as s		
	with con		29b. Signature and title of certifier			2	9c. License				29d. Da	te signed (M			
	THE		30. Name and address of person who con	mpleted cause of de	eath (Item 23a) (Tv	pe, Print\	04	7094					77.1		
	10		VEL NATEGAN	1415	S-DIV S	nei	sac	15 BUA	4	MI	21	804			
	Stat Registra		31. Date filed (Month, Day, Year)  DEC 19 20	32. Registra	eath (Item 23a) (Ty	par	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42466 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Anne Arundel Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 5/31/1917 298-09-4343 Months Hours Min. **Director** 1 **X** M 2 □ F Ohio 84 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location Director 10d. Inside City Limits Anne Arundel Maryland Annapolis 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21403 302 First Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates. W 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 X Widowed 4 Divorced Completed WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Salesman Restaurant Equipment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Tudd DeAloia Carmella 19a. Informant's Name/Relationship (Type, Print) 302 First Street, Annapolis, MD 21403 Blaise DeAloia - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore Crematory | 12/13/2011 | Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION Physician/ PNEUMON/A disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner NEUMONIA ASSOCIATEL TEALTH CAME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami Hospital or Attending Physician; The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year Pregnant at time of death the 1 ☐ Yes ∠ ☐ Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has stuneral director, page 2 s performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other: 1 Yes ပ To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title

State Registrar PArkway

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 anueva

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42467 Certificate of Death Reg. No. nt's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ NO 7.340M 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Davs Hours Min (Month, Day, Year 220-56-2307 Director 1 🗆 M 2 🖊 F 5 1929 Maryland 82 Yrs. Apr Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland notified at Director Shady Side Maryland Anne Arundel 1 Tes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ò ms 23a or must be r Funeral 20764 USA 1291 Scott Town Rd. ural", or items 2 I Examiner mus death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian 11. Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes Give Specify: **Black** Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 6th College (1-4 or 5+) Marriott Hotel Housekeeper Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ၉ Edmond Jackson Mary Wilkerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1291 Scott Town Rd. Shady Side, Md. 20764 Mary Offer(Daughter) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Flage Pispesition (Name of Date or other place) ■ Burial 2 □ Cremation 3 □ Removal from State AME Church 12-15-11 Galesville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 44 Marne a Recens conf F&ilitSons Mortuary, 1922 Forest Dr. Annapolis, 21401 Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Physician/ Due to (or as a consequence of) ATION disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy jo in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death Yes detached been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2- No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2: autopsy performed Yes 2 this certificate 25. Was case referred to medical completely filled in by the funeral director, 26 Place of Death (Check only one) Hospital Other: 2 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury 1 Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of certific 29c. License number signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type Name and address of person

Registrar

DHMH 17 Rev 06-2011

State

gistrar's Signature

**DEC 1 4 201** 

11-09411 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 42468 State of Maryland / Department of Health and Mental Hygiene Edna L. Duckett 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day December 14, 2011 1539 hrs Medical Examiner Edna Duckett 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's Southern Maryland Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number Funeral Months Davs Hours Director 2 X F 9-8-38 Maryland 1 M 218-38-9695 73 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 No or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Maryland Charles Waldorf Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 3605 Moses Way, Apt. 326 20602 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 2 X No 1 Yes If Yes, Give Year or Dates: 1 Yes 2 X No specify: 3 Widowed 4 Divorced Specify: Black 2 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 Homemaker Domestic 18.Mother's Name (First, Middle, Maiden Sur 17. Father's Name (First, Middle, Last) Be Holiday Richard Porter 19a. Informant's Name/Relationship (Type, Print ) ۹ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Duckett/Husband 3605 Moses Way Apt. 326, Waldorf MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Department of He Important: If its injury or other t crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12-20-11 Brandywine MD Gibbons Cem 4 Donation 5 Other Specify. 22. Name and Address of Facility 21. Signatur Funeral Service Licenses Adams Funeral Home Pa Aquasco Md 20608 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Mudical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical attending physician a UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Live birth Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) by the atter 1 Yes 2 No 9 V Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus, Obesity, End stage renal disease Completed After this certificate has been a meral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 28b. Time of Injury 28c. Injury at Work? 28a, Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 1 🗹 Natural after death.

Director: A 5 Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City within 24 hours after or To the Funeral Direc 3 Suicide 6 Could not be determined Homicide 29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 15, 2011 O.C.M.E

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ling Li, MD

31. Date filed (Month, Day, Year) 32. Registrar's Signature 2011

Registrar

Charles	Herman	Duckett
Olimico	1 ICIIII aii	Daonott

	1- For State Registrar	Cer	tificate of Death	Reg	g. No.	
Physician	1. Decedent's Name (First, Midd	le,Last)		Date of Death     Month	Day Year	3. Time of Death
Medical Examine	Chartes	H	Duckett	December	15, 2011	1451 hrs
	4a. Facility Name (if not institution	the state of the s	4b. City, Town, or Locati Brookeville	ion of Death	4c. County of Death  Montgomery	'
	400 Greenbridge Roa			Under 24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birt	tholace (State or
Funeral Director	5. Social Security Number 579-94-0616	6. Sex 7. Age (In yrs. la		ours Min. 6-17-	Foreig	
any .	Usual Residence of Decedent 10a, State 10b, County	10c. City.	Town or Location			10d. Inside City Limits
<b>≥</b> .tt	Manualand	-				1 X Yes 2 No
Aaryland 28a-f show 1 at once.	Maryland Balt	imore   Mic	ddle River	10	g. Citizen of What Cour	ntry?
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s 23a e noti	9412 Windpir	12. Was Decedent Ever in U.	S. 13. Was Decedent of Hispanic			can Indian, Black,
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once. To Be Completed by Finneral Director	1 Never Married 2 XM	larried Armed Forces?	If Yes, specify Cuban, Mexi	ican, Puerto Rican, etc.)	White, etc.	
	3 Widowed 4 Di	vorced If Yes, Give Year	1 Yes 2 No spec			lack
natura xami		ecify only highest grade completed)	16a. Decedent's Usual Occupation (G during most of working life. DO N		16b. Kind of Business/I	<sup>ndustry</sup> on Sanitar
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ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical To Be Comple	Charles 19a. Informant's Name/Relation:	H ship (Type, Print)	19b. Mailing Address (Street and	.ndra M. Number or Rural Route Numb	per, City or Town, State	, Zip Code)
	Kisha Ducket	t/Wife	9412 Windpine	Rd, Middle	River MD	21220
ore, M es 1 and 2 of Health If item 2	20a. Method of Disposition	20b. F	Place of Disposition (Name of cemetery crematory or other place)	/, Date	20c. Location - City or	Town, State
Baltimore, Pormit. Pages 1 and Department of Healt Important: If item niury or other tran	1 X Burial 2 Crematio 4 Donation 5 Other S	T S T Kellioval Ilolii State	Heritage Cem	12-22-11	Waldorf, N	Maryland
Baltimo permit. Page Department of Important: injury or ott	21. Sign ture of Funeral Service		22. Name and Address of Fa	icility		
E.E.S.E	Thursa 9	leal.	Adams Funer	al Home PA,	Aquasco N	
Physician	23a. Part I. Enter the disease, of failure, List only one cause		Do not enter the mode of dying, such a	as cardiac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final disease					Death
Project of	or condition resulting in death)	Due to (or as a consequence or	f):			
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	cause. Enter Underlying Cause (Disease or injury that initiated	c.  Due to (or as a consequence of	0.			
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760, icate be exe physician the burial -	IF FEMALE:	23c. If yes, outcome of preg			23d. Date of delivery	<u> </u>
		Live oliti	-11-	topic pregnancy	Month [	Day Year
D. Box 68760, the death certificate by the attending physic by the attending physic ched for use as the burny physician/Mee	1 Yes 2 No 9 Un	4 Pregnant at time of de	other (Specify)			
P.O. B that the d ned by the detached		The state of the s	esulting in the underlying cause given in	n Part I. 23e. Did tob	bacco use contribute to	the cause of death?
, P.( res that signed be det.				1 Yes	2 No 3 Prob	oably 4 🗹 Unknown
Division of Vital Records, P.O. rat of vital Records, P.O. rat or Attending Physician: The law requires that the rather death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact artification: To Be Completed by P.			<del></del>	24a. Was a		itopsy findings available completion of cause of
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Vital I ysician: ysician: his certifi director,	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other	4 Nursing Home 5 F	Residence 6 🗸 Other	r: Scene
n of Vi ding Physi L. After this funeral dir		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at V		ow injury occurred	
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Divisi pital or Att ours after d teral Direct filled in by	3 Suicide 6 Cou	ld not be 28e. Place of Injury - At he	ome, farm, street, factory, office building	g, etc. 28f. Location (S or Town, St	treet and Number or Ruate) 400 Greet	ral Route Number, City
Division o oppital or Attending hours after death.  Internal Director: After the filled in by the function:	4 Homicide		in River	Brookvi	Lle,MD.	
		hysician: To the best of my knowled	ge, death occurred at the time, date and noter investigation, in my opinion, deat	d place, and due to the cause h occurred at the time, date a	e(s) and manner as state and place, and due to the	ed. ne cause(s)
To the Ho within 24 To the Fu Complete!	29b. Signature and title of certifi	and manner stated.	29c. License num		29d. Date signed (Mo	
		-7/-	O.C.M.E.	00.41	December 16, 20	
	1 Reodere M	who completed cause of death (Item	. D .			
1	Theodore M. King, Jr	· ·	Examiner 900 W. Baltimore	Street, Baltimore, MD	21223	
State			ire barl			
Registra	TI III 1282	UII Denova D.	19 aura			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Z For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 1625 M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner KING If Under 24 Hr 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Min Nov 29 1 **№** M 2 🗆 F Months Davs Hours 1933 Indiana 220-32-9573 78 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits with the Maryland 10a. State 10b County 10c. City, Town or Location notified at Director 1 Yes 2 No MD Kent Galena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 pe Funeral ral", or items 23a Examiner must b U.S.A. 12821 Chesterville Rd. 21635 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 2 No 1955 à Maryland 21215-0036 hours after White 1 Yes 2X No Specify: If Yes, Give Year or Dates. Specify. "natural", 3 Widowed 4 Divorced -1958Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Luggage Manufacturer Industrial Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Carl C. Doll Ethel Gustafson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Shirley Doll P.O. Box 292 (wife) Galena, MD. 21635 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Kent Cremation Services 1/4/12 Smyrna, DE. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Functal Servi 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech any M00510 118 West Cross St. Galena. MD. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or contrion resulting in de th) Physician/ Medical Due to (or as a d Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Cause (Disease or liniury and that initiated events resulting in death) Last Due to (or as a consequence attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Year Month Dav Pregnant at time of death 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has performed 1 Yes 2 No certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ည Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 🔀 Natural 5 Pending Accident Suicide Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [ 29b. Signature and title of 29d. Date signed (Month, Day, Year) D0045688 poleted cause of death (Item 23a) (Type, Print) 30. Name and address of p BRUWN ST muchons. 31. Date filed (Month, Day, JAN 0 5

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ December 13, 2011 7:45 A. James H. Elgin, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Rocky Ridge 10270 Rocky Ridge Rd Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday **Funeral** Hours 213-42-7246 Director 1 ☎ M 2 ☐ F 02/02/1942 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2 X No Frederick Rocky Ridge 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21778 USA 10270 Rocky Ridge Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. an "natural", or iter Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. <u>}</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the USDA-ARS Agnonomist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ont of Health and Mental Hit: If item 27 is marked off yor other traumatic even ပ James H. Elgin, Sr. Mattie Weaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Elgin/wife 10270 Rocky Ridge Rd., Rocky Ridge, MD 21778 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🛂 Cremation 3 ☐ Removal from State Department of Important; If any injury or 12/14/2011 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Frederick, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ untis INFARCTION MYDCARDIAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Year 3 CORONARY MRTERY DISEAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to forces a consection reburial-tra that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 the use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown □ Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ALZUEMERS DISEASE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an HYPERTENSION After this certificate has funeral director, page 2 autopsy perform performed? Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After 1 iniury 5 Pending Accident Investigation within 24 hours after death To the Funeral Director: Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 14686 Attuna

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Registrar

State

31. Date filed (Month, Day, Year)

FREDERICK

DRIVE

Warne and address of person who completed cause of death (Item 23a) (Type, Print)

HUSSAN N

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MD

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Gerald A. December 10:40 A<sup>M</sup> Fleming Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's 45345 Barefoot Lane California 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🗙 M 2 🗆 F Months Hours 02/07/1938 New Mexico 73 Director 522-44-9097 Usual Residence of Deceden 3a or 28a-f show t be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a mit. Page 1 and 2 should be filed within 72 hours after death with natment of Health and Mental Hyglene.

The starts if item 27 is marked other than "natural", or items 23 injury or other traumatic event, the Medical Examiner must injury or other traumatic event, the Medical Examiner must. 45345 Barefoot Lane 20619 United States 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status þ 1 Never Married 2 K Married ▼ Yes 2 □ No f Yes, Give Baltimore, Maryland 21215-0036 Specify:White 1 ☐ Yes 2 K No Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Program Manager <u>Government</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gerald A. Fleming 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45345 Barefoot Lane, California, Maryland 20619 Pearl Fleming-Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or other 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield Echols 12/18/2011 | Charlotte Hall, MD 21. Signification of the Company of Santivasci M 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 20650 22955 Hollywood Road, Leonardtown, MD M00872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition metastata Physician. sareoma Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of) attending physician for use as the burial Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months
1 Yes 2 No signed by the a 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available 24a Was an Hospital or Attending Physician: The law r 24 hours after death. Funeral Director: After this certificate has b prior to completion of death? performe 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Injury at 28d. Describe how injury occurred 2 No ျ ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🗌 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 5 Pending ✓ Natural 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident 2 Accident
3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0668120 12-16-11 m. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D 23415 Three Notch Road, California, MD 20619 Shah, State

DHMH 17 Rev 7/2009

Registrar

DEC 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 42473 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician/ 0400 QM Iola Elizabeth Ferguson December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Valley Lee 18943 Hodges Lane 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, 9 / 26 / Months Hours 1 M 2 X F 89 Director 579-18-6896 1922 09/ Virginia Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 1 🗌 Yes 2 😾 No Maryland St. Mary's Valley Lee 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a United States 20692 18943 Hodges Lane ed other than "natural", or items event, the Medical Examiner mu 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " College (1-4 or 5+) Elementary/Seconday (0-12) Healthcare Owner Manager 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever 2 Gertrude Nance 0ra Harry Thomas Plowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i 4621 Saul Road, Kensington, Maryland 20895 Gordon Lee Ferguson - Son other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) George Episcopal 12/22/2011 Valley Lee, Maryland 21. Sint of Find Service Constantiva CC Kathleen A. Santivasci M00872 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Chronic Obstructive Pulmonary Disease Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence on Cause (Disease or iinjury that initiated events and burial-tran resulting in death) Last Due to (or as a consequence of) physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending phys for use as the l IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed funeral director, page 2 should be det þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 👿 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident 24 hours after death Funeral Director; A Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Sianature December 20, 2011 My D31563 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10) eme Great Mills Road, Suite 203, Great Mills, MD 20945 <u>Charles Benner,</u> M.D

DHMH 17 Rev 7/2009

State

Registrar

2 2011

DEC 2

11-09620	
Anais Fournier	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nais Fournier		1- For State	of Marylan		rtment of tificate of			Menta	l Hygien		, No. 20		42471
Physicia	an/	<b>Registrar</b> 1. Decedent's Name (First, Middle,La	st)							of Death		3.	Time of Death
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Funeral		Social Security Number 6. 8	Sex 7	Age (In yrs. Ia	ast birthday)		r 1 Year	If Under 2	24Hrs. 8. Dat	e of Birth	(MM/DD/YYYY) 9.	Birthpl	ace (State or
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-19ho injury or other traumante event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship			19b. Mailing	Address					ber, City or Town, S	state, Z	p Code)
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Baltimore, permit. Pages 1 at Department of He Important: If ite		4 Donation 5 Other Specif	y:		se Hill				12/30/2	011	Hagerst	own	, Maryland
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Box death death d for u	ıysi	1 Yes 2 No 9 ✔ Unknow	vn 9 Unknowr	1	3 Ott	ier (ope							
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Div	Certification:	Suicide 6 Could no determine							or	Town, St	tate)		
Division  To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /		29a. Certifier 1 Certifying Physical Concept Physical Certifying Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier 1 Certifier 1 Certifier	clan: To the best o	f my knowled examination a	ge, death occur	red at the	time, dat opinion,	te and place death occ	ce, and due to urred at the tin	the caus	e(s) and manner es and place, and due	stated to the	cause(s)
To I	Medical	29b. Signature and title of certifier	and manner stat	ed.	-		c. License				29d. Date signed		
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		30. Name and address of person wh	o completed cause	of death (Item	n 23a)						L		
Ţ		Ana Rubio MD. Assist	ant Medical Ex			more S	Street, E	Baltimor	e, MD 212	23			
S <sup>i</sup> Regis	tate trar	31. Date fled (Month, De)(Yea)	Denes 32. Regi	stran's Signat	acked								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 19, 2011 18:50 December Richard Alvin Greene Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George Clinton If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Hours Min 236-60-8207 Usual Residence of Deceden **Director** 1 😾 M 2 🗆 F 76 Aug. 8, 1935 Washington, D.C. 28a-f show 10a. State within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ¥ Yes 2 ☐ No Temple Hills Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20748 United States 4323 Delmar Ave. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 X Married 1 X Yes 2 If Yes, Give Year or Dates. 2 🗌 No Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced and Mental Hygiene.
is marked other than "natural aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) P.G. County Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic eve Edna Mae Johnson Roosevelt Theodore Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carrie H. Greene / Wife 4323 Delmar Ave. Temple Hills, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/28/2011 Cheltenham, Md. Md. Veterans Signature of Funeral Service Licens 22. Name and Address of Facility 20747 Part 1. Enfer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACCIDENT CEREBROVASCULAR Physician/ ACUTE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CARDION TOPATHY Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director. After this certificate has been signed by the attending physician and reley filled in by the funeral director, page 2 should be detached for use as the burial-transit ATRIAL FIBRILLATION that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FAILURE WITH TRACHEOSTOMY 1 Yes 2 No 3 Probably 4 Unknown RESPIRATORY Were autopsy findings available prior to completion of cause of death? HYPERTENSION 24a. Was an autopsy performe 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural iniury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

42476

State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar		Oldio of f	viai yiai	,	tificate of l	Death	, 0	eg. No.		
Physicia	in/	1. Decedent's Nam		,					2. Date of Deat	h	Year.	3. Time of Death
Medi	cal	Lew:		and Gordon give street and number,				1 - C (B)	Decembe			5:35 PM
Examir	ier	25120 L:		-	,			r Location of Death ywood	1	4c. County	of Death Mary	's
Funeral		5. Social Security N	lumber			ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birthp	lace (State or Foreign
Director		249-09-0 Usual Residence o		T CAPIVI 2 C. IP	9	2 Yrs.	World S Bayo	TIOUIS IVIII.	July 22	, 1920	Sou	ch Carolin
land show d at	ţō	10a. State	10b. County		10c. Cit	y, Town or Loc	ation	- 1			1	Od. Inside City Limits
Mary 28a-1 notifie	Jirec	MD	St. M	ary's	Ho	11ywood	_					1 Yes 2X No
vith the 23a or st be i	ral	10e. Street and Nu	Lindner	Lano			10f. Zip Code 206:	26	1	Og. Citizen of V		•
tems er mu	<b>Funeral Director</b>	11. Marital Status	IIIdile1	12. Was Deceden	t Ever in U.S	S. 13. W		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		e - America	
after d	by	1 Never Mar		Armed Forces ed 1 X Yes 2 If Yes, Give			Yes, specify Cuba		Rican, etc.)	Blac	k, White, e	tc.
atural	Completed	3 Widowed		Year or Dates.							Whi	
in 72 h e. ian "n Medi	ldmo		cify only highe	st grade completed)  College (1-4 or	. 5.4)	Give k	ent's Usual Occup ind of work done ( ) NOT use retired)	during most of worl	king	16b. Kind of B	usinėss Ind	lustry
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be file antal H ked of c ever	To B	17. Father's Name		,					ne (First, Middle, N		,	
ind Me s marl umati		19a. Informant's Na	-	olmes Gordo ip (Type, Print)	<u>n</u>	19b. Mailine	Address (Street	MO11y and Number or Rui	Frances			ode)
alth a n 27 is er tra		Nevada	L. Gor	ion – Spous	e	1		er Lane			2063	. '
per nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2	oosition Cremation	3  Removal from Stat		Place of Dispos emetery, crem		(e)		20c. Location -	-	
it. Pagartmen artmen ortant: injury		4 ☐ Donation 21. Signature of Fu	5 Other (S	pecify)	Brı	nsfield	1-Echols	Cre 12/2	9/2011			a11, MD
permit Decar Impor any in		11/1/11		insfield Jr	አለበብ	052 22.	Name and Addre Brinsfie	ss of Facility 22 1d Funera	1933 HOLL 11 Home,P	$\cdot A \cdot M_{21}$	ka.,L	eonardtown d 20650
		23a. Part 1. Enter t shock, or hea	the disease, or or the failure. List or	complications that cause	ed the deatl	n. Do not enter	the mode of dyin	g, such as cardiac				Approximate Interval Between
hysician/ Medical		Immediate Cause ( disease or condition resulting in death)		a. Foil	ure:	to Yhr	eve, A	PULT-			all	Onset and Death
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tificate be executed ng physician and as the burial-transi	Examiner	Cause (Disease or that initiated events resulting in death)	S	c Due to (or as	a consequ	ence of:						
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as as	Medical	IF FEMALE:	-	d								
ndii use	ian/	23b. Was decedent in the past 12 i		23c. If yes, outcome 1 Live Birth	2 🗌 Feta	I death 3 🗌	Ectopic pregnanc	;y		1	e of delive	
ne dea / the a ched f	Physician/	1 Yes 2 9 Unknown	No	4 ☐ Pregnant 9 ☐ Unknown		leath 5 □	Other (specify)			Мо	ntn	Day Year
that the ned by e detail	by P	Part II. Other signif	icant condition	s contributing to death	but not res	ulting in the un	derlying cause giv	en in Part I.	23e. Did tob	acco use contr	ibute to the	e cause of death?
quires en sig ould b	ted								1 🗆 Ye	s 2 XNo	3 🗌 Prob	ably 4 🗆 Unknown
law re has be e 2 sh	Completed								24a. Was an autops	y F	rior to con	sy findings available apletion of cause of
n: The ficate vr, pag		25. Was case referre	ad to modical	<del></del>					perform 1 Tes 2		leath?	2 🗆 No
Physician: 7 or this certifica eral director, p	To Be	examiner?	No	Hospital:	tient 2 🗆	ER/Outpatient	Othe	er:	k only one) ome 5 🛭 Reside	C \( \tau \)		
ng Ph fter th ineral		27. Manner of Death 1 🖸 Natural	5 Pending	28a. Date of inj	ury	28b. Time of injury	28c. Injury work	/ at	28d. Describe hov			
ttendi death. tor: A the fu	Certificate	2 Accident 3 Suicide	Investiga	ation			M 1 🗆	Yes 2 No				
al or A s after I Direc d in by		4 Homicide	determin	28e. Place of In building, ei	jury - At hoi tc. (Spec <i>ify)</i>	me, tarm, stree	t, factory, office		28f. Location (Str. City or Town,		er or Rural i	Route Number,
lospita t hours uneral ed fille	Medical	29a. Certifier 1	Certifying I	Physician. To the best o	f my knowle	edge, death oc	cured at the time,	, date and place, ar	nd due to the caus	e(s) and manne	er as stated	l.
To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for the funeral director.		only one) 3	Certifying	aminer of the basis of Jurse Practioner to the	examinati∩n	and or investig	ation, in my opinic ath occurred at the	n, death occurred a e time, date and place	t the time, date and ce, and due to the	l place, and due cause(s) and ma	to the cau nner as sta	se(s) and manner stated ted.
5 5 K E		29b. Signature and t	tyre of certifier				29c. License			d. Date signed		-
	-	30. Name and addre	ess of person w	no completed cause of	death (Item	23a) (Type, Pri		110		2-28.	201	/
ene				all. M.D.				oad Suit	e 2054	Califo	rnia.	MD 20619

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)
DEC 2 9 2011

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Diane Gransky 2011 4:53 Medical December 11. 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Severna Park 618 Jumpers Hole Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours Min 58 220-46-3420 **Director** 1 - M 2 - F Feb. 15,1953 Maryland Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Anne Arundel Severna Park 1 Yes 2X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 618 Jumpers Hole Road 21146 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. "natural", or þ 1 Never Married 2 XMarried Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: White Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene.

is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Charles Volz Jeanne Crouch traumatic permit. Page 1 and 2 should Department of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Martin Edward Gransky /Husband 618 Jumpers Hole Road Severna Park, MD 21146 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place) Dec. 13, 2011 Baltimore, MD Metro Crematory, INC 4 Donation 5 Other (Specify) 21. Signature of Mery I Service 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer Ph\_sician/ a disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Leat Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year detached the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed Yes 2 1 🗌 Yes 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) . Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier соmpletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D39505 December 12, 2011 Kan

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

305

egistrar's Signature

Hospital Dr. Glen Burnie, MD. 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

Physicia		Registrar	cate of Death	Reg. No					
al Exami		1. Decedent's Name (First, Middle,Last) Andrea Lorraine Gill		2. Date of Death  Month Day  December 22,	3. Time of Death 1314 hrs				
		4a. Facility Name (if not institution, give street and number) 534 Broad Street Lot 7	4b. City, Town, or Location of Dea Perryville		c. County of Death Cecil				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 285-60-9633 1 M 2xF 35		lin. Oct. 10,	1/DD/YYYY) 9. Birthplace (State or Foreign Ohio Country)				
w any	-	Usual Residence of Decedent  10a. State	n or Location Perryville		10d. Inside City Lim				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Director	10e. Street and Number 534 Broad Street Lot No. 7	10f. Zip Code 21903	10g. Ci	tizen of What Country?				
eath with the	Funeral D	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue		14. Race - American Indian, Black, White, etc.				
ours after de itural", or aminer mu	à.	1 Yes 2 X No 3 Widowed 4 Divorced if Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a.	1 Yes 2 No specify:		Specify: White Kind of Business/Industry				
uid be filed within 72 ho Mental Hygiene. marked other than "m event, the Medical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Twelve Years	during most of working life. DO NOT use r Homemaker		Personal Residence				
l be filed vental Hygi	å	17. Father's Name (First, Middle, Last) Andre Magruder		me (First, Middle, Maide Linda F	ox				
id 2 should lith and Mi m 27 is ma	2	Kevin V. Gill (husband)	9b. Mailing Address (Street and Number of 534 Broad Street Lo	ot 7, Perry	•				
Pages I an ment of Hea tant: If iter or other tra		1 X Burial 2 Cremation 3 Removal from State 2 Park		.2/31/11 I	Jamestown, Pennsylvania				
		21. Fignature of Funeral Service Licensee  23a. Part I. Enter the disease, or complications that caused the death. Do r	22 Name and Address of Facility Lee A. Patterson Perryville, M	Maryland 21	L903 <b>–</b> 0766				
nysician Medical Kaminer	9 17	failure. List only one cause on each line.	razolam Intoxication		Between Onset a				
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e execute ian and ial - trar	Medical								
e be ex ysician burial	<u>ŏ</u>	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)							
ath certificate be ex attending physician or use as the burial	sician/Me	past 12 months?	2	gnancy	Month Day Year				
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	To Be Completed by Physician/N	past 12 months?  1 Yes 2 No 9 V Unknown  Part II. Other significant conditions contributing to death but not resulting to death b	26.Place of Death (Checoupatient 3 DOA Other, Nurvey 1 Death of Death (Checoupatient 3 DOA Other, Nurvey 28c. Injury at Work?  d01:09 pm unknown farm, street, factory, office building, etc.  Residence	23e. Did tobacce  1 Yes 2  24a. Was an autopsy performed?  1 Yes 2  ck only one)  rsing Home 5 Resid  28d. Describe how in subject or Town, State)  Perryvill  and due to the cause(s) and at the time, date and perposed	24b. Were autopsy findings availar prior to completion of cause death?  No 1 Ves 2 No  dence 6 Other: Scene injury occurred  verdosed and Number or Rural Route Number, Ce, Md.  and manner as stated.				
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Virginia Ella Gray 06:40 December 27 Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Somerford Assisted Living Frederick Frederick Social Security Number 6. Sex If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) Months Hours (Month, Day, Year) 177-16-8365 1 M 2 X F 90 May 05, 1921 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2100 Whittier Drive 21702 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, George A. Roupe Merle Matlick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Gray/ Son 24428 Hanson Rd. Gaithersburg, MD 20882 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Forest Lawn Gardens 4 ☐ Donation 5 ☐ Other (Specify) Dec. 31, 2011 McMurray, Pennsylvania 22. Name and Address of Facility Keeney and Basford Funeral Home 106 E. Church St., Frederick, Maryland 21/01 21. Signature of Funeral Service Licensee M01646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final andrami disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 month Pregnant at time of death Month .Year 2 No

Physician/ Medical Examiner

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Division of Vital Records, P.O. Box 68760

Physician/

Examiner

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**Director** 

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permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Medical

Examine Physician/Medical

ate has been signed by the atter page 2 should be detached for u Completed by Be မ Certificate:

Part II.

completely filled in by the funeral director, the Hospital or Attending I hin 24 hours after death. the Funeral Director: After within 2 To the I

> State Registrar

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Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death?  21 No 3 Probably 4 Unknown
		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?

			1 L Yes 2 No   L Yes 2 L No	
25. Was case referred to medical examiner?		26. Place of Death (Chec		
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ D0	OA Other: 4 Nursing H	lome 5 Residence 6 Other (Specify)	
27. Manner eath  1 latural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
One Cartifies 1 Contitute Physic	Salama Tariffa in the control of the	CALL Alice and allege	amel elve to the construction of the construct	

9b.	Signature an	d title of certifier	29c. License number	29d. Date signed (Month, Day, Year)					
	only one)	3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
		2 Medical Examiner: On the basis of examination and/or investigation							
ga.	Certifier	Certifying Physician: To the best of my knowledge, death occur	red at the time, date and place, and due to the	cause(s) and manner as stated.					

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

65 C 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month HUNT MARY ELIZABETH 2011 2:30p Dec Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Lanham 9603 Beechwood Ave. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 NC **Funeral** Age (In yrs. last birthday) 8. Date of Birth 1 □ M 2 🕱 F Min. Nov. 30 rear 923 NC Director 230-20-0370 88 Usual Residence of Decedent 28a-f show 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2X No Lanham Prince Georges 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral USA 20706 9603 Beechwood Ave. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give 2 🗶 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Completed Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other to Families 12th Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lee L. Thomas Annie Bell Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 20 Galveston Pl. SW #B Washington, DC 20032 Jacqueline Campbell-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 12-21-2011 Oxford, NC Meadowview Memorial of Funeral Service Licenses Marshall-March Funeral Home of Maryland Suitland, Md 20746 4308 Suitland Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physiciani End Stage Senile Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exam Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and -trar Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Year Pregnant at time of death ed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ Cerebralvascular Accident 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page perform death? 1 Yes 2 No 1 Yes 25. Was case referred t edical examiner? 26. Place of Death (Check only one) Be Hospital 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending death. 2 Accident 1 Yes 2 No Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4041 Bowder Mill Rd Calverton, MD

DHMH 17 Rev 7/2009

State Registrar Kouatchou

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Day 7:27 A M Denise B. Wells Hall 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince George's Clinton Social Security Number If Under 24 Hrs. . Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** If Under 1 Days Hours Director 88 578-30-3151 1 🗆 M 2 🗓 🗶 F Washington, DC 06/19/1923 show 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits with the Maryland must be notified at Director 28a-f 1 X Yes 2 No Washington DC None 0 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 20018 2306 14th Street NE Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc "natural", or Completed by 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Housewife 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Wells Lavenia Beach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zio Code) 7007 Mason Street District Heights, MD 20747 Columbus Hall/Son item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once, cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/29/11 Suitland, MD Cemetery 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licenses Suitland Road Suitland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on ea Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Ecquentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-tran resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE use 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery in the past 12 month 1 Yes 2 No for Month Pregnant at time of death the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۇ ك page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autops 1 Yes 2 No Yes the funeral director. 25. Was case referred to proceed Be 26. Place of Death (Check only one) examiner? Hospital Other: ပ 1 🗌 Yes 2 4 No 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural 5 Pending Accident Investigation Director Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the base of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Control Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title o . Name and address of person who complet cause of d ath (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Aloysius Hayden, Sr. December 18. 2011 2:20p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospice House of St. Mary's Callaway Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 216-22-3553 Yrs Director 81 03/08/1930 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 X No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 22680 Cedar Lane Court #1101 20650 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 Married ☐ Yes 2 🛣 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gertrude Francis Roger Hayden Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41913 Sara Ann Ct., Leonardtown, MD 20650 James R. Hayden/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. John's Catholic 12/22/2011 Hollywood, MD Signature of Fune/al Service Licensee 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
41590 Fenwick St., Leonardtown, MD 20650 23a. Par 1. Enter the disease, or complish tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shyck, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin -transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 2 No signed by the a d be detached f 1 ☐ Yes 2 ☐ Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics 25. Was case referred to medical Hospice Be 26. Place of Death (Check only one) Other: House 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work' 2 Accident 5 Pending 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

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29b. Signature and title of certifie

Jennifer

Schmidt,

30. Name and address o

68760

Box

P.O.

Division of Vital

erson who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

D.O.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

H005575

40900 Merchants Lane, Leonardtown, MD 20650

29d. Date signed (Month, Day, Year)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

		State of Maryland / [	Department of Health and Mental Hy	giene 2011 12183					
Physic Med		- State Registrar Amended #20B Date-12/27/11,  1. Decedent's Name (First, Middle, Last)  Frederick John Hahne	2. Date of De Month 12	Reg. No. L O					
Exam		4a. Facility Name (if not institution, give street and number)  38080 Indian Creek Drive	4b. City, Town, or Location of Death Charlotte Hall	4c. County of Death St. Mary's					
Funera Directo	•	5. Social Security Number 6. Sex 7. Age (In yrs. last birti	thday) If Under 1 Year If Under 24 Hrs. 8. Date of Bir (Months, Days Hours Min. (Month, Days) 1/19/	th y, Year) 9. Birthplace (State or Foreign Country) New York					
21215-0036 within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show, the Medical Examiner must be notified at	Funeral Director	Usual Residence of Decedent	n or Location  Lotte Hall  10f. Zip Code 20622  13. Was Decedent of Hispanic Origin? (Specify Yes or No-	10d. Inside City Limits 1 ☐ Yes 2 ☑ No  10g. Citizen of What Country? USA  14. Race - American Indian,					
-0036 ours after de atural", or ite cal Examine	<u>\$</u>	1 ☐ Never Married 2 😾 Married 3 ☐ Widowed 4 ☐ Divorced  Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerfo Rican, etc.)  1 ☐ Yes 2 🌠 No Specify:  Decedent's Usual Occupation	Black, White, etc. Specify: White					
Maryland 21215-0036 2 should be filed within 72 hours after thth and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Completed	(Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)  1 2  Au	16b. Kind of Business Industry  Auto Dealership						
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re, Marylanc 1 and 2 should be file if Health and Mental F item 27 is marked of other traumatic even			Moleski Hahr  Mailing Address (Street and Number or Rural Route Number)  B080 Indian Creek Drive Cha						
the search		20a, Method of Disposition 20b, Place of	of Disposition (Name of ry, crematory or other place) 11/19/2012 and Veteran's Cem 12/28/2011	20c. Location - City or Town, State Cheltenham, MD					
Baltimore permit. Page 1s Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licensee M00817	22. Name and Address of Facility Brinsfield 30195 Three Notch Road Ch						
De executed  By the executed Physician and P	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	23c. If yes, outcome of pregnancy in the past 12 months? 1  Yes 2 No  23c. If yes, outcome of pregnancy 1  Ectopic pregnancy 4  Pregnant at time of death 5 Other (specify)						
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he law require has been age 2 should	Completed	recent resection	24a. Was auto perf						
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Later of Attending Physician: The law requires rs after death.  In Director, After this certificate has been signed in by the funeral director, page 2 should by	Certificate: 1	27. Manner of Death 28a. Date of injury 28b. T	Time of njury M 28c. Injury at work? M 1   Yes 2   No 28d. Describe	how injury occurred  Street and Number or Rural Route Number,					
the Hospita hin 24 hours the Funeral	Medical	(Check 2 ☐ <b>Medical Examiner:</b> On the basis of examination and/o only one) 3 ☐ <b>Certifying Nurse Practioner:</b> To the best of my knowl	death occured at the time, date and place, and due to the cor investigation, in my opinion, death occurred at the time, date eledge, death occurred at the time, date and place, and due to the time.	and place, and due to the cause(s) and manner stated ne cause(s) and manner as stated.					
Noriti		29b. Signature and title of certifier	29c. License number 035345	29d. Date signed (Month, Day, Year)					
84 LVA		30. Name and address of person who completed cause of death (Item 23a) ( F. GEO RGE LEON 326/ OLD U	(Type, Print) NASHINGrow ROAD JUALDOR	F, MD 20602					
St: Regist	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature	hadel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 3:25 ANN MARGARET HANF Dec Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis MultiMedical Towson Baltimore Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Couptry) Maryland Months Days Hours (Month, Day 85 217-20-5385 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10d. Inside City Limits : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 🗌 Yes 2 🛣 No MD. Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4309 Necker Avenue 21236 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Excavating Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Amrein Howard Ruth Esther Phipps George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Woodbine Ave. David H. Kinhart (Son) Towson, Maryland Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dec. Date 28. 1 💢 Burial 2 🗀 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Watters Cem. 2011 Jarrettsville, MD. Signatur 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Maryland Home, P.A. 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician END STAGE ENAL disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ₺ been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, completed filled in by the funeral 28a. Date of injury (Month, Day, Year) ë 27. Manner of Death 28b. Time of 28c. Injury at 28d, Describe how injury occurred work?
1 Yes 2 No Natural injury 5 Pending Certifica Accident Investigation 6 Could not be Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certific 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. \$ignature and title of certifier 29d. Date signed (Month, Day, Year) D0060560

Registrar
DHMH 17 Rev 7/2009

5/8

State

PHILADELPHIARB # 206

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 25 per me 9924 2-2-12 vt State of Maryland Poepartment of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Marcus HICKS 9:07 AM Dec Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harbor Hospital city Ballimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0Ct 11 1977 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🕅 M 2 □ F **Director** Maryland 217-17-0962 34 Yrs. Usual Residence of Decedent 28a-f shov 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Lothian Anne Arundel 1 Yes 2 X No 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? pe ms 23a must be Funeral 903 A Bayard Rd. 20711 USA and 2 should be filed within 72 hours after death "natural", or iten edical Examiner 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 💥 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black 3 Divorced Completed er than "natur the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Anne Arundel Co. Elementary/Seconday (0-12) College (1-4 or 5+) 12th 4yrs Teacher Board of Education and Mental Hygie is marked other Department of Health and Mental Hyg Important; If item 27 is marked othe any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unobtainable Yvonne Hicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brandy Blake-Hicks(Wife) 903 A Bayard Rd. Lothian, Md. 20711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Adams U.M. Church 20c. Location - City or Town, State Page 1 Date 1 X Burial 2  $\square$  Cremation 3  $\square$  Removal from State 12-17-11 Lothian, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee WMame a Receise of Facility Sons Mortuary, 1922 Forest Dr. Annapolis, Md. res 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ Phic Shock disease or condition resulting in death) Medical (or as a consequence of): Examiner piration meymonio Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events -transit unte Kersistant Kea S and resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day 1 Yes 2 9 Unknown 2 No signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s 24a. Was an autopsy performed?

☐ Yes 2 🗶 No certificate 1 ☐ Yes 2 No **Division of Vital** within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 X Yes Z X NO Other: ည 1 XInpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 🔼 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month. Day, Year) Resident DESOCO 12-7-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed Ahmed 3001 5 Hanover St. Baltimore MD Date filed (Mon 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2011 42486

		1- For State Registrar	ate of warys		Certifica			IG WIEIT	tarriyg		g. No.	UI	1 4240
Physicia Medical Examii		Decedent's Name (First, Midd     Sarah Anne								Date of Death Month December	1		3. Time of Death
		4a. Facility Name (if not institution		umber)		41	b. City, Town, c	r Location o		December	18, 2011 4c. County o	f Death	1237 1115
		Anne Arundel Medica					Annapolis				Anne Aru	ındel	
Funeral Director		5. Social Security Number 217–35–1250	6. Sex		yrs. last birt 19	hday) Yrs.	If Under 1 Ye			03/19	/(MM/DD/YYYY) /1992		hplace (State or n <sub>untry)</sub> Maryland
Aaryland 28a-f show any 1 at once.	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne  10e. Street and Number	Arundel	10c	. City, Town	or Locatio	Arno	1d		I 10	g. Citizen of Wh	at Coun	10d. Inside City Limits  1 Yes 2 X No
i the Ma		294 Ternwing	Drive					210	12		_	SA	
0036 within 72 hours after death with the Maryland giene. ser than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once.	by Funeral		1 Yes vorced If Yes, Give Yes or Dates:	orces? 2 X er	No	If Ye	Decedent of Hs, specify Cuba	ın, Mexican,	gin? ( Specii , Puerto Ric	fy Yes or No- an, etc.)	14. Race White		can Indian, Black,
hours "natur		<ol> <li>Decedent's Education (Spe Elementary/Secondary (0-12)</li> </ol>		· ·			s Usual Occupi st of working life				16b. Kind of Bus	iness/Ir	ndustry
036 thin 72 ne. than	15. Decedent's Education (Specify only highest grade completed)   16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)   16b. Kind of B						Educa	atio	n				
P 2 2 2 3 1	Be	17. Father's Name (First, Middle, Charles Ha	1big					K	ath1e	en Pie			
	٩	19a. Informant's Name/Relations Kathleen Halb:		er							per, City or Town		Zip Code)
- 5 7 5 2	1	20a. Method of Disposition 1 Burial 2 Cremation		T	20b. Place o	_	ion (Name of ce			ate	20c. Location -		Town, State
Baltimore, permit. Pages l a Department of He Important: If ite		4 Donation 5 Other Sp	pecify:	om state		ont l	Mem Gar						ille, MD
Ball permit Depart Impor	Į	21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Laboratory 147 Duke of Gloucester St, Annapolis											
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that c	aused the d	death. Do no	t enter the	mode of dying	, such as ca	ardiac or res	spiratory arres	st, shock, or hea	rt TTS	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death)				is							Death
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Esopha Due to (or as a			Perf	oration	s		<del>.</del>			
4.7	aminer	cause. Enter Underlying Cause (Disease or injury that initiated											
cuted ind transit	Exa	events resulting in death) Last	d		•								
760, icate be executed physician and the burial - transit	Medical	X UNPENDED	AMENDED	23a-b,	,27,pe	r me	,g925 3	-1-12	sm				
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unk	LIVE	oirth nant et time		=	il death 3 er (Specify)	Ectopic	pregnancy		23d. Date of o Month		ay Year
P.O. I	집	Part II. Other significant conditi	lons contributing to	death but	not resulting	in the un	derlying cause	given in Pa	rt I.				he cause of death?
duires that			<del></del>								2 No 3		
Cords, e law require, has been s	Completed	· · · · · · · · · · · · · · · · · · ·								24a. Was ar autops perforn	y pr		opsy findings evailable ompletion of cause of
Vital Reco ysician: The law his certificate has director, page 2 s		25. Was case referred to medical	i	_			26.Plac	e of Death (	(Check only	1 Yes 2	No 1	<b>√</b> Ye	s 2 No
Vita hysicia this ce	To Be	examiner? 1 ✔ Yes 2 No	Hospital: 1	Inpatient :	2 🗹 ER/Ou	tpatient		Other <sub>4</sub>	Nursing H		Residence 6	Other:	
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be		27. Manner of Death  1 X Natural 5 Pend 2 Accident Inves	28a. Date (Month stigation	of Injury , Day,Year)	28b. T	ime of Inj		ury at Work		i. Describe ho	ow injury occurre	d	
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could 4 Homicide deter		e of Injury -	At home, fa	rm, street,	factory, office	building, etc	c. 28f	Location (St or Town, Sta		r or Rur	al Route Number, City
Div To the Hospital or within 24 hours after to the Funeral Div completely filled in	edical	one) 2 Medical Exar	nysician: To the bes miner:On the basis and manner s	of exeminat	wledge, dea ion and/or in	th occurre vestigatio	ed at the time, d	ate and plan, death occ	ce, and due	to the cause time, date a	(s) and manner nd place, and du	as state	d. cause(s)
	Σ	29b. Signature and title of certifie	w				29c. Licens				29d. Date signe December		
010			ssistant Medica	l Examir	er 900	W. Balt	imore Stree	et, Baltim	ore, MD	21223			
Sta Registr		31. Date filed (Month, Day, Year)	2011 32.86	egistrar's Si	gnature	hou	4				•		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9=15 AM 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arme Avende Croston Convalescent enter NO-Hou 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛣 F Month, Day Year) 4/26/1916 Months Min. Mary Land 214-26-0934 95 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Maryland Anne Arundel Annapolis 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21401 105 McKendree Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc Page 1 and 2 should be filed within 72 hours after d ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No White Specify: Completed 3 X Widowed 4 □ Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 years Elementary/Seconday (0-12) Special Education School Teacher permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leonard Fisher Rosaline Cristy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet R. Zadera/ Daughter 105 McKendree Ave., Annapolis, MD 21401 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 12/15/11 Annapolis, MD 21. Signature of June e Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ereprocioniscular Bola Immediate Cause (Final Physician/ AtheroGlevotiz disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that the death certificate be executed ending physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death 9 Unknown 5 Other (specify) Month Year signed by the aid be detached for 1 Yes 2 L P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? death? 2 No 2 4 N Yes Division of Vital 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending after death. 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 1-A Diana idevater Colony

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month

Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year KYYAM Hannak hillip December 201 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Hospital The Johns Hopkins Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Min th, Day, Year) 266-11-9117 1**X**] M 2 □ F 59 Feb. 1, 1952 Florida Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 🖵 Yes 2 🗌 No MD Prince George's Bowie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 15618 Emery Court 20716 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, d Forces' Armed Forces 1 XYes 2 If Yes, Give Year or Dates Black, White, etc. 1 Never Married 2 Married 2 □ No Navy 1 ☐ Yes 2 ▼No Specify Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Telecommunication Supervisor US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phillip Jeff Hannah, Sr. Beulah Pratt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara W. Hannah - Spouse 1710 Granite Court, Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State verters, crematory or other place) Verterans Cemetery Crownsville ΜD 4 Donation 5 ☐ Other (Specify) (a 12-20-2011 Crownsville, MD ignature of Funer | Service | icensee 72. Name and Address of Facility Beall Funeral Home nun 6512 NW Crain Hwy, Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) (or as a consequence of): Carinoma HeDato Cellular Due to (or as a consequence of IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

ARITY INTON Medical . Examiner

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24 hours after death.

Funeral Director: After this

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Division of Vital Records,

Physician/

Medical

Examiner

**Funeral** 

**Director** 

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Baltimore, Maryland 21215-0036

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Completed

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Certificate:

Medical

29a. Certifier

Sequentially list conditions, if any, leading to immediate that initiated events resulting in death) Last

Pregnant at time of death 2 No g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

23e. Did tobacco use contribute to the cause of death? 1 Yes

Month

2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy

1 Yes 2 No

Day

Year

25. Was case referred to medica 2 No 1 Yes Manner of Death

26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred

Natural 5 Pending Accident Investigation □ Accider
 □ Suicide 6 Could not be 4 Homicide determined

28c. Injury at work? 1 ☐ Yes 2 ☐ No injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 29b. Signatur

🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number

29d. Date signed (Month, Day, Year) December

use of death (Item 23a) (Type Print)

(000) timore

State Registrar

 Date filed (Month) DEC 1 4 201

Registrar's Signature

54

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended 1 - State #7, FH, TCHD, pha 12/9/11 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1541 xrie targrove 2011 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 579-03-0355 02-23-1921  $\overset{\text{Country})}{\mathsf{N.C.}}$ **Director** 1 □ M 2**X**) F 9087 Usual Residence of Deced 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland **Funeral Director** 10d. Inside City Limits the Medical Examiner must be notified at Md. Talbot St. Michaels 1 Yes 2 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? items 23a 23996 St. Michaels Road 21663 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, et þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White If Yes, Give Year or Dates 3 ☐Widowed 4 ☐ Divorced Completed Specify: Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Restoration Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Arthur Arrington Wood Amanda Maude 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard D. Hargrove / Son 24000 St. Michaels Rd. St. Michaels, Md. 21663 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Olivet Cemetery 12-11-2011 St. Michaels, Md.21663 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen Hurrican And Ostrowski Funeral Home P.A. Osteswiti Joseph m. P.O. Box 518 St. Michaels, Md. 21663 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ VIE disease or condition MMEDIATE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last nding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 You
9 Unknown Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ORTIC STENOSIS Completed 3 Probably 4 .Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed Ves 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 🗌 Yes 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of D ath Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending s after death. 1 🗌 Yes 2 No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely f (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar 31. Date filed (Month, Day, Year) NFC 0.9 2011

29b. Signature and

KEVIN J.

and address of person who completed cause of death (Item 23a) (Type, Print)

N T. O'KEFE MD 2503 Mad (CA) MEDICH Registrar's Signature

MD

PARKWAY SUITE 100

29d. Date signed (Month, Day, Year)

ANNAPOUS MO, 2146.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December Day 17 3:20р м 2011 Rose Marie Hennessy Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Hospital Cecil Elkton 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 1 M 2 T F Months Days Hours Min. Westtry)Grove 50 1/29/11-44/1961 **Director** 229-02-2585 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Cecil Elkton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 691 Augustine Herman Hwy 21921 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2¥ No Specify: Completed 3 Widowed 4 2 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Aide Home Health care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wells Stidoms Norma Harden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43 Hickory Lane, Elkton, MD 21921 Jessica Nunley Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Oxford Cemetery 12/21/11 Oxford, PA 19363 22. Name and Address of Facility Edward L. Collins Funeral 21. Signature of Funeral Service Licensee PA 19363 Pine Oxford, Home, 86 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Mus 0 disease or condition Medical resulting in death) Examiner a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of). attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be e 24 hours after death, Funeral Director, After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 📉 No Day ate has been signed by the a page 2 should be detached in 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed After this certificate 1 Yes 2 No the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: မ 1 Tyes 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work 1 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State e Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination apol or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To type best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one)

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

DEC 22 201 ature

30. Name and address of person who completed cause of death (It

m 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 11 Physician/ DECEMBER HAYES, JR 4:52 pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 235-20-5589 If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 ፟ M 2 □ F 88 Months Hours April 8 West Virginia <sup>rear</sup>1923 Director Usual Residence of Decedent show 10a. State 10b. County with the Maryland notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2 🐼 No Maryland Frederick Frederick 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral items 23a 6009 Greenfield Drive 21703 United States be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Armed Forces? Black White etc ō 1 Never Married 2 Married <u></u> Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 🔀 No Specify: White 'natural", Specify: Completed 3 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) th and Mental Hygiene. 27 is marked other than ' traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Security Guard Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Earl Hayes, Sr. Opal Tucker Page 1 and 2 should? 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Doris Hayes / Wife 30 North Place, Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dec. Date 3. 1 Burial 2 Cremation 3 Removal from State Resthaven Crematory 5 Other (Specify) 4 Donation 2011 Frederick, Maryland Signature of uner I S ice Licensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease shock, or heart failure L , or complications that caused the death Approximate Interval Between Immediate Cause (Fina Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine If any leading to immulacause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed -fransi and resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death the be detached Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific, completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 M No Other: 은 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of-Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature nd title of certifier 29d. Date signed (Month, 1X mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #12 per FH 12/16/2011 CCD0H/ ba

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 Hawkins Mary 10:00p Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 45795 Sayre Dr St.Marvs Mills Great Birthplace (State or Foreign Country) Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 6. Sex 7. Age (In vrs. last birthday) Months Davs Hours (Month, Day, Year) 73 **Director** 213-38-4064 1 🗆 M 2🗶 F 12-17-1937 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 X Yes 2 No Maryland Prince George Brandywine 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 13620 Tower Road 20613 USA items ? Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married ō þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 'natural", Specify: Black Completed 3 Widowed W Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene is marked other tha Southern MD Hospital Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Eugene Plater Dorothy Savov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 45795 Sayre Dr. Great Mills MD 20634 Veronica Ireson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Heritage Cem 12-17-11 Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Funeral Home Pa, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last and Due to (or as a conce attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown signed by the detack Part II. Other significant conditions contributing to death but not esulting in the under king cause given in Hai 23e. Did tobacco use contribute to the cause of death? <u>6</u> OU 1 Yes 2 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed 24 hours after death.

Funeral Director: After this certificate 1 Yes 25. Was case referred to medical director. and rathers 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Hospital 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature 29c. License numbe 2 29d. Date signed (Month, Day, Year) 30. Name and address of person who co (Item 23a) (Type, Print) 700 Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <sup>Day</sup>2, 20°11 December 2:40 Leda Harnish Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Hagerstown 20646 Beaver Creek Road Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, 1 🗆 M 2 🔭 F Days Hours Maryland **Director** 1935 June 214-32-4280 Usual Residence of Decedent 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Hagerstown Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20646 Beaver Creek Road 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married β Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: 3 Divorced 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien ris marked other th Grocery Cashier Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic o Virginia Houser Daniel Spielman Naomi injury or other traumatic John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20646 Beaver Creek Rd., Hagerstown, MD 21740 George F. Harnish / Spose 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 12/24/2011 Hagerstown, Maryland Rest Haven Cemetery 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ ONGESTIVE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** WARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or iinjury that initiated events and -trar Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical Box 68760 nding t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ ó in the past 12 months Day Year 4 ☐ Pregnant at time of death g ☐ Unknown ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b sign I be Records, DIABETES MELLITUS. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed FICIEN CY 2 No Yes Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA : After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? or 24 hours after death.

e Funeral Director: After the function is a second to the function in the function i 2  $\square$  No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier сотріете 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within To the

State Registrar 29b. Signature and title of certifier

30. Name and address of person who

31. Date filed (Month,

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completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 927 SACKSON 2011 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MARYLAND Med. Gr BAHIMONE, MD N/A If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Aug 20 219-84-7132 48 Yrs. ea 963 Pennsylvania **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County withIn 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Crownsville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 930 Johnson Grove Lane 21032 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 1 Yes 2 XNo Specify: it. Page 1 and 2 should be filed within 72 hours an artment of Health and Mental Hygiene. Specify: Completed 3 Widowed 4 NDivorced Black Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th 0 Employed Sprinkler System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alvin Jackson Sr Celma Dennison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti Agitate Ct. Annapolis, Md. 21409 Tatiana N. Jackson(Daughter) 1608 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗓 Cremation 3 🗀 Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 12-8-11 Baltimore, Md. Signature of Funeral Service Licenses Windame Reverse of Sciil Sons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Phy ir ian Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu and title of certifie address of person who cor cause of death (Item 23a) (Type, Print) BAltimore MD 21201 Melinostry 31. Date filed (1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#26 per HHY.
State of Maryland
Registrar 12/12/2011 AACO HEALTH DEPT (MH) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ORNAN AMES 025 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anné Arundel Severna Park 142 McKinsey Road Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) Months Days Hours **Director** 213-42-5531 1 M 2 D F 1943 Washington DC 67 Dec. 26, show 10a. State with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Arlington Arlington 1 X Yes 2 □ No VA 10e. Street and Number ö 10f. Zin Code 10g. Citizen of What Country? be items 23a oner must be Funeral 22206 U.S.A. 3077 South Woodrow Street death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? Black, White, etc. or, þ 1 X Never Married 2 ☐ Married National Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after "natural", If Yes, Give 1 Yes 2 No Specify White Completed 3 Widowed 4 Divorced Year or Dates. Guard Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than " event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) OMD Budget Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Hitem 27 is marked or other traumatic even and Mental ၉ Francis Xavier Jordan Geraldine Ruth Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Alewine - Bro.-in-law 142 McKinsey Road, Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Donation 5 Other (Specify) 12-12-2011 Heaven Cem. Silver Springs, MD eral Servi 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ BLADDER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Due to (or as a consequence of) Exami physician and s the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
 5 Other (specify) detached for Day Pregnant at time of death Month Year the 9 Unknown Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 5 this certificate has autopsy performe Hospital or Attending Physician: The 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: Brother inlaws ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 52 R 27. Manner of Death 28c. Injury at work?
1 Yes 2 No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practition To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie completed gay se of death (Item 23a) (Type, Print) DEFENSE

State Registrar

31. Date filed (Month, Day

2

DHMH 17 Rev 06-2011

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Sylvetta Johnson Dec 2011 Medical 10: 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1525 Kingshi<u>ll Street</u> Mitchellville Prince George's 8. Date of Birth
(Month, Day, Year)
2-13-1922 Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Days 1 M 2 5 Min **Director** 579 44 7695 Yrs 89 Usual Residence of Decedent 28a-f shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County with the Maryland **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits Prince George's Mitchellville 1 🖁 Yes 2 🗌 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1525 Kingshill Street 20721 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 6th Housewife Private 27 is marked other r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Virgie Richards James Hayes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Johnson/ Daughter 1525 Kingshill Street Mitchellville, MD20721 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1
Department of I
Important: If it
any injury or or 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 12/20/2011 Clinton, MD Signature of Funeral Service 22. Name and Address of Facility Briscoe-Tonic Funeral Home moeur? resci -10nuc 2294 Old Washington Rd.Waldorf, MD20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition end Stage Senile Dementia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of, Physician/Medical Exami Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicis Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death Unknown signed by the at Id be detached fo P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hypertension Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown certificate has been sirector, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 🗵 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2X No ပ္ 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No completed filled in by the Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 only one 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) Fouchthou Jocelyne 163748 12/15/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou MD 20705 MD 4041 Powder Mill Rd Calverton

DHMH 17 Rev 7/2009

State

Registrar

Barks

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 24 Melinda Faye Kohn 2011 11:45A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 40960 Medley's Neck Road Leonardtown St. Mary's 5. Social Security Number **Funeral** 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Months 02/ 02, 212-94-3110 1970 Maryland **Director** Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director Maryland St. Mary's Leonardtown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22472 Armstrong Drive 20650 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White Completed 3 Divorced 4 Divorced d 2 should be filed within 72 hours. alth and Mental Hygiene.

1 27 is marked other than "natura er traumatic event, the Medical E. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Lead Financial Analyst Government Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F ၉ Alice Faye Williams James I. Gatton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 22472 Armstrong Drive, Leonardtown, Maryland 20650 Richard Kohn-Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Brinsfield Echols 12/28/2011 Charlotte Hall, MD. 21. Signature of Fineral Ser 22. Name and Address of Facility 22955 Hollywood Road, Leonardtow Maryland 20650 Brinsfield M00052 Brinsfield Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Hudgkins Onset and Death Physician/ Medical resulting in death) Examiner 2 yrs 8 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy Pregnant at time of death in the past 12 months? 5 Other (specify) 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician: The law requires 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home s after death.

I Director: After this d in by the funeral d Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hin 24 hours af the Funeral Di npleted filled ir Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0068120 12-27-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Minal Shuh imp (6) eme 23415 Three North 20619 Road

Registrar

State

31. Date filed (Month, Day, Year)

DEC 28 2011

2. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 30, per DVR, g923 1-5-12 sm
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 26, 2011 Frederick 8:06  $A^{M}$ Forthman Keefer, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 13511 Cherry Tree Circle Hagerstown Social Security Number . Sex 1 **X** M 2 □ F Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. (Month, Day, Ye Days Hours Maryland Director 217-10-2908 96 16, 1915 May Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 13511 Cherry Tree Circle 21742 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry المالية. معالم Hygiene. معالم المالية. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with. Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic... Watch Repairman Jewelry Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick F. Keefer, Sr. Emma Belle Kreps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13511 Cherry Tree Circle, Hagerstown, MD 21742 Frederick F. Keefer, III/Son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place)
Rest Haven Cemetery 1 X Burial 2 Cremation 3 Removal from State 1/3/2012 Hagerstown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S.Men 21742 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or componentiations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate rval Betweer Onset and Death Immediate Cause (Final ONG late Physician/ -Aclula disease or condition resulting in death) Medical Due to o as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and I-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day 1 Yes 2 L 9 Unknown 9 Unknown the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No Yes 2 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: 21/ Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) hours after death.

neral Director: After this
d filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 29b. Signature and title of certifie 201 30. Name and address of person who completed cause death (Item 23a) (Type, Print) 13424 Pennsylvania Ave Steven Hatleberg Ste: 203 Hagerstown, Md, 21742 32. Registratis Signature 31. Date filed (Month, Day Year) 2012

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene O. D. L.

		1 = State Registrar	ertificate of Death	Reg.	2011	42499			
Physic Med		1. Decedent's Name (First, Middle, Last) Shirley Lewin		2. Date of Death Month	Day Year 16 201	3. Time of Death 1 12:02 A M			
Exami		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death				
Funera		Gilcrest Hospice Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Columbia  V) If Under 1 Year   If Under 24 Hrs	8. Date of Birth	Howard	thplace (State or Foreign			
Directo	_	NONE 1 □ M XXX F 72 Yrs	Months Days Hours Min.	(Month, Day, Yea	ar) Co	ountry)			
nd how	٦,	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location	08/22/193	9   38	amaica  10d. Inside City Limits			
//aryla 8a-f s tified	recto	MD Howard Savag				1X Yes 2 □ No			
h the N a or 2 be no	Funeral Director	10e. Street and Number 8928 River Island Drive Apt. 301	10f. Zip Code 20763	10g.	Citizen of What Co	ountry?			
ath with	uner	11. Marital Status 12. Was Decedent Ever in U.S. 1	Jamaica						
ter des	by Fi	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 2 ▼ No If Yes, Give	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	14. Race - Ame Black, Whit	e, etc.			
OUS af tural" al Exa	ted	Year or Dates.							
Z I Z I 3-UU36 Within 72 hours after giene. er than "natural", o the Medical Exam	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of wor . DO NOT use retired)	king	o. Kind of Business.	/industry			
withir sygiene her the	ပို		ster of Religeon		Church				
be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last)		me (First, Middle, Maid	len Surname)				
ary and Me s mark	1	Harty Wilkins  19a. Informant's Name/Relationship (Type, Print)  19b. M.	Wilhel ailing Address (Street and Number or Ru		or Town. State. Zi	p Code) 20763			
nd 2 sl nd 2 sl ealth a m 27 ii		Georgia Genwright/ Daughter 892	8 River Island Dri	ve Apt. 30	1 Savage	,Maryland			
Daltimore, IMaryland ZIZID-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at, any once.		1 → Burial 2 ☐ Cremation 3 ☐ Removal from State   cemetery, c	sposition (Name of rematory or other place)  Cemetery Jan.		nish Town. Cather:	Town, State n ine, Jamaica			
permit. Departi Import any inji		1 1//	22. Name and Address of Facility Ma 4308 Suitland Road	rshall-Mar	ch Funera	al Home			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between			
Pnysician Medica	-	Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a consequence of):	CANCER			Onset and Death  4EARS			
Examine									
sit d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter through the cause are the through the cause are the through the cause are the through the cause are the cause ar			//				
of ou tificate be executed ng physician and s as the burial-transit	Exan	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	PALIF. B. BALL						
e be e ysiciar re buri	Medical	d							
		IF FEMALE:							
attendin for use	Physician/	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	B		23d. Date of de Month	elivery Day Year			
that the des ned by the a	hysi	9 Unknown							
s that es that igned be de	β	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.			o the cause of death?			
aw requires as been sig	eted			-		Probably 4 Unknown			
D = - B	Completed			24a. Was an autopsy performed	prior to death?	completion of cause of			
ician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (Che	1  Yes 2 🗶	No 1 □ Ye	s 2 L No			
Physician: T Physician: T this certifica	은	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat  27. Manner of Death 28a. Date of injury 28b. Time		lome 5 Residence		city) HOSPICE			
Attending I death. ctor: After y the funer	icate	1 Natural 5 Pending (Month, Day, Year) injur		28d. Describe how in	njury occurred				
reter t	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St		ıral Route Number,			
To the Hospital of within 24 hours af To the Funeral Discompletely filled in	Medical	29a. Certifier (Check (Check only one) (Certifying Physician: To the best of my knowledge, deal of the best	estigation, in my opinion, death occurred	at the time, date and pl	ace, and due to the	cause(s) and manner stated.			
To the To the Complex complex		29b. Signature and title of certifier	29c License number	204	Date signed (Mont	th, Day, Year)			
		20 Name and address of a	064343	1 3	ECEMBER	R16,2011 UD 21044			
12		30. Name and address of person who completed cause of death (Item 23a) (Type DANIEUE DOBERMAN, MD 633	D64395 6 CEDAR LAN	E COLL	MBIA, A	UD 21044			
Sta	ite	31. Date filed (Month, Day, Year)	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42500 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 1:35 a.m. Arthur December Charles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Solomons Nursing Center Solomons 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number **Funeral** Age (In vrs. last birthday) 1 🛣 M 2 🗆 F Days 09 Month, Pay, Hours 85 Indiana T926 565-24-7566 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d, Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location must be notified at Director 1 🗆 Yes 2 😾 No Maryland St. Mary's Hollywood 10f. Zip Code 0 10e. Street and Number 10g. Citizen of What Country? 23a Funeral United States 20636 45010 Millstone Lane items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black White etc. ō 1 Never Married 2x Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Manual Writer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည pe t Pau1 Monroe Α. LaMarr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Rosalie Anderson LaMarr-Spouse 45010 Millstone Lane, Hollywood, Maryland 20636 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 12/21/2011 4 Donation 5 Other (Specify) Charlotte Hall, MD. Brinsfield-Echols 21. Signature of Funeral Service Light Danielle Ward M01403 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Cardiomyopathy Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or Illijury that initiated events resulting in death) Last that the death certificate be executed burial-tran Due to (or as a consequence of) Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Preanant at time of death signed by the a Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 No 은 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work?

Box 68760 P.O. Division of Vital Records,

5) Rme

death.

hours after death neral Director: A I filled in by the f

hin 24 hours a the Funeral D mpleted filled

Charles Benner, 31. Date filed (Month, Day, Year)

Medica

2 Accident
3 Suicide

4 Homicide

29a. Certifier

(Check

29b. Signature and

Investigation 6 Could not be

determined

**DEC 20** 

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D31563

🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

1 Tyes

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

2 🗌 No

29d. Date signed (Month, Day, Year) 12/19/2011

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20945 Great Mills Road, Suite 203, Great Mills, MD

32.

Registrar